

HEALTH

Nashville and Davidson County, TN 2002

Metropolitan Public Health Department of Nashville and
Davidson County, TN

311 23rd Avenue North

Nashville, TN 37203

<http://healthweb.nashville.org>

Davidson County Community Health Assessment Series

No. 1 Davidson County Mortality Report 1995

No. 2 Davidson County Natality Report 1996

No. 3 The Health Status of Davidson County 1990 - 1996

No. 4 The Health Status of Davidson County's Fourteen Planning Districts 1990 - 1996

No. 5 Health Pulse Companion 1998

No. 6 Notifiable Diseases 1990 - 1997 Davidson County, Tennessee

No. 7 1997 Mortality Assessment, Davidson County, TN

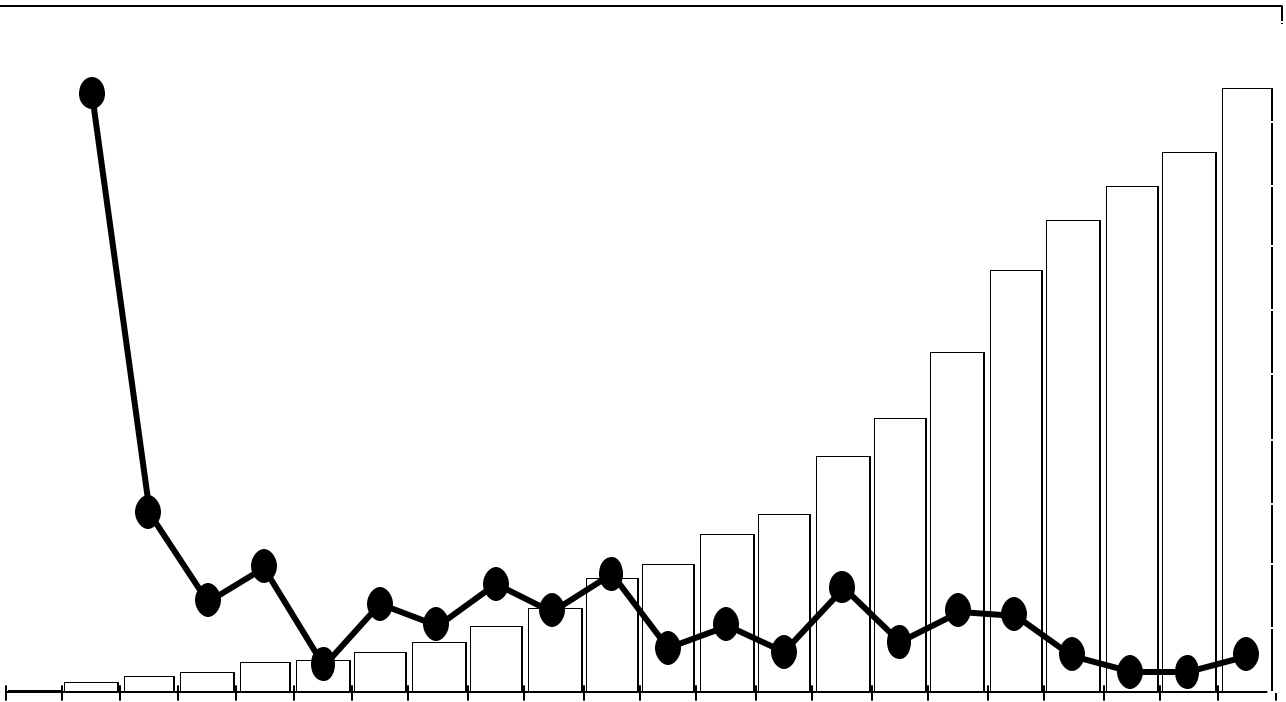
No. 8 Sexually Transmitted Diseases in the 1990's in Davidson County, Tennessee

No. 9 Davidson County, Tennessee Fetal and Infant Mortality Report, 1989-1998

No. 10. Health, Nashville and Davidson County, TN, 2002

Health, Nashville and Davidson County, TN, 2002

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Bureau of Community Assessment and Health Promotion
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Health Nashville and Davidson County, TN 2002

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Health, Nashville and Davidson County, TN, 2002

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Message from the Director of Health

I enjoyed reading this document. I will issue a caution, however; it is loaded with information useful for assuring that our collective efforts are targeted towards creating a healthy and **PREFERRED FUTURE** for our community. The Metro Public Health Department's mission is to provide health protection, promotion, and information products to everyone in Nashville so they can enjoy healthy living free from disease, injury, and disability. This document is an example of our products, the most comprehensive look at health status determinants for Nashville.

The opportunity to deliberately move towards obtaining the Healthy People 2010 objectives is now. On too many of the national benchmarks, Nashville comes out exceedingly below. On too many of the issues, the disparity gap has been evident for the past decade with no evidence of changing. Hopefully you will join with me in evaluating our total current efforts throughout the city in light of the data and push to do the next thing, be earnest about putting into activity those best practices and lessons learned through research or experience; and courageously give up those things that are not "moving our numbers" towards healthier outcomes.

It is my pleasure to present *Health, Nashville and Davidson County, TN, 2002* to you. It will cause our departmental efforts to be more focused and I expect, yours. In eight years, we want the national report card to reflect that more of the 2010 objectives are met in this community rather than not.



Stephanie B. C. Bailey, MD, MSHSA
Director of Health

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Overall responsibility for preparing this report rested with the Division of Epidemiology, Bureau of Community Assessment and Health Promotion, under the general direction of Bart N. Perkey, Director of the Bureau.

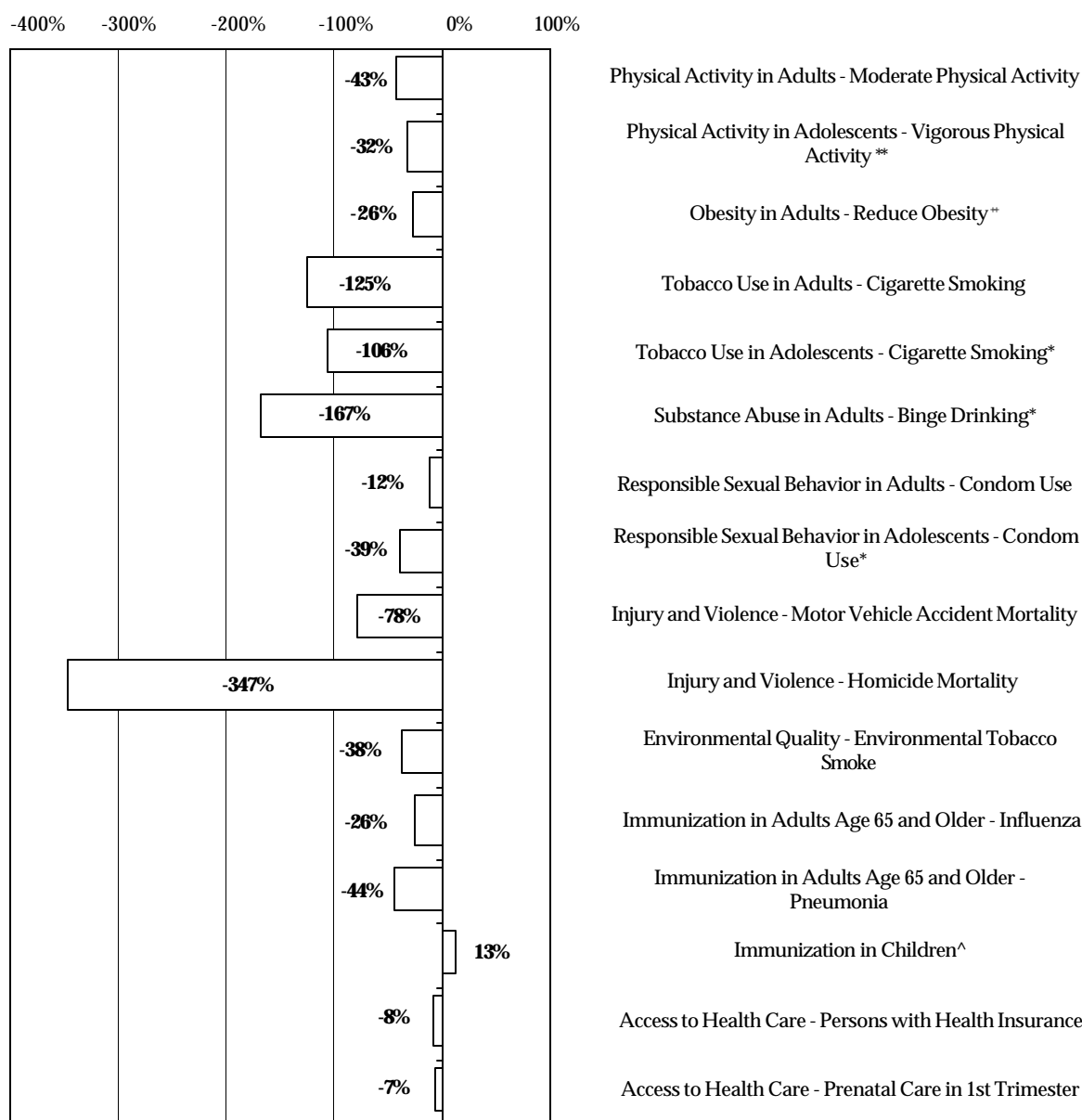
The project team consists of Dr. Jianshi (Jesse) Huang (Team Leader), Nancy Horner, Melissa Garcia, Brook McKelvey, Ami Sklar, and Jim Jellison.

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Selected Highlights: Healthy People 2010 Leading Health Indicators for Nashville, Tennessee

Percent Difference Between Nashville Rates and Healthy People 2010 Goals

Negative Percentages = Nashville not reached goal
Positive Percentages = Nashville surpassed goal



*Further information regarding these health indicators is available from Metropolitan Public Health Department but has not been included in this report.

**A proxy measure was used to estimate adolescent vigorous activity in Nashville. See Technical Note 20 for more information.

++The obesity estimate for Nashville may be an underestimate. See Section 2.2.2 for more information.

^A proxy measure was used to estimate child immunization in Nashville. See Technical Note 21 for more information.

Selected Highlights -- Healthy People 2010 Leading Health Indicators

Indicator / Healthy People Objective	Brief Description	National 2010 Target	Nashville's Current Status	Difference between Nashville and 2010 Target
Physical Activity				
Objective 22-2	Adults - moderate physical activity	30 %	17%	-43 %
Objective 22-7	Adolescents - vigorous physical activity	85 %	58%	-32 %
Overweight and Obesity				
Objective 19-2	Adults - reduce obesity	15 %	18.90%	-26 %
Objective 19-3c	Adolescents - reduce overweight and obesity	5 %	ND*	
Tobacco Use				
Objective 27-1a	Adults - cigarette smoking	12 %	27%	-125 %
Objective 27-2b	Adolescents - cigarette smoking	16 %	33%	-106 %
Substance Abuse				
Objective 26-10a	Adolescents - no alcohol/illicit drugs	89 %	ND	
Objective 26-10c	Adults - illicit drug use	3 %	ND	
Objective 26-11c	Adults - binge drinking	6 %	16%	-167 %
Responsible Sexual Behavior				
Objective 13-6	Adults - condom use	50 %	44%	-12 %
Objective 25-11	Adolescents - condom use	95 %	58%	-39 %
Mental Health				
Objective 18-9b	Treatment for depression	50 %	ND	
Injury and Violence				
Objective 15-15a	Motor vehicle accident mortality	9	16	-78 %
Objective 15-32	Homicide mortality	3.2	14.3	-347 %
Environmental Quality				
Objective 8-1a	Persons exposed to ozone pollution	0 %	ND	
Objective 27-10	Environmental tobacco smoke	45 %	62%	-38 %
Immunization				
Objective 14-24	Children age 19 to 35 months - fully immunized**	80 %	90%	13 %
Objective 14-29a	Adults over age 65 - influenza vaccine	90 %	67%	-26 %
Objective 14-29b	Adults over age 65 - pneumococcal vaccine	90 %	50%	-44 %
Access to Health Care				
Objective 1-1	Persons with health insurance	100 %	92%	-8%
Objective 1-4a	Source of ongoing care	96 %	ND	
Objective 16-6a	Prenatal care in first trimester	90 %	84%	-7%
*ND=No data available.				

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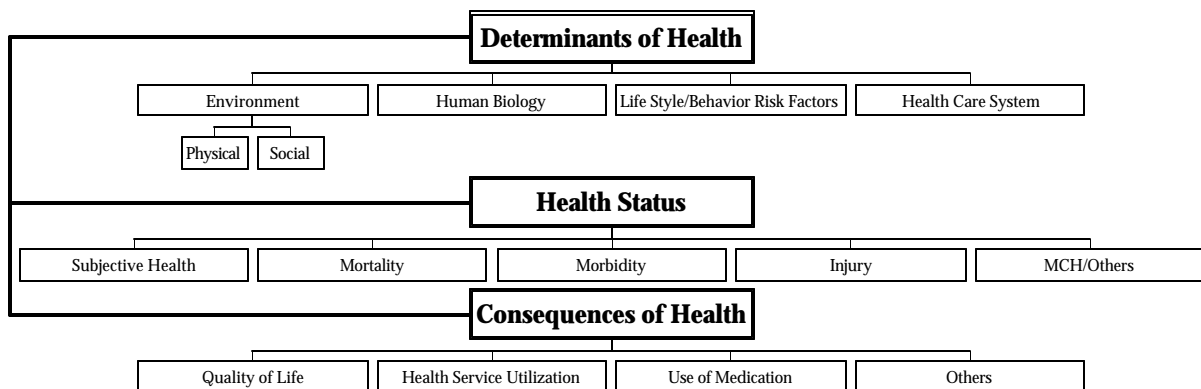
What is Health?

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

World Health Organization (WHO) 1946

Health is ... seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capacities.

World Health Organization (WHO) 1986



Chapter One

Introduction to Health Model

Assessment of community health status is one of the three core public health functions identified by the Institute of Medicine (IOM)'s landmark report, the *Future of Public Health*.¹ IOM's 1996 follow-up document reiterated the definition of assessment as the regular systematic collection, assembly, analysis, and dissemination of information on the health of the community.²

Metropolitan Public Health Department of Nashville and Davidson County (In this report, Nashville and Davidson County will be referred to as "Nashville", and Metropolitan Public Health Department of Nashville and Davidson County will be referred to as "MPHD".) commits to identify and prioritize community health needs and convey an awareness of these needs to the community. In 1995, MPHD began formally collecting and analyzing data as a part of an ongoing community health assessment. Assessment has subsequently become one of the essential functions of MPHD to materialize our mission: to provide health protection, promotion, and information products to everyone in Nashville so they can enjoy healthy living free from disease, injury, and disability.

Health Model

Health, Nashville, TN, 2002 is the result of MPHD's ongoing community health assessment effort. For this report, we have chosen, from the many theoretical approaches to defining health, the definitions proposed in 1946 and in 1986 by the World Health Organization (WHO)^{3, 4} as the theoretical basis for the Nashville Community Health Assessment Model:

Health is a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity. (1946)

Health covers "the extent to which an individual or group must be able to identify and to realize aspirations, to satisfy needs, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capabilities." (1986)

Using WHO definitions, we adopt an operational model for Nashville's community health assessment. This model is based on two recognized frameworks^{5, 6}: 1) Mobilizing for Action through Planning and Partnership (MAPP) Community Health Status Assessment Framework and 2) the Canadian Health Survey Framework.

The MHD's operational model of health consists of three main levels (Figure 1):

1. Determinants of health,
2. Health status, and
3. Consequences of health.

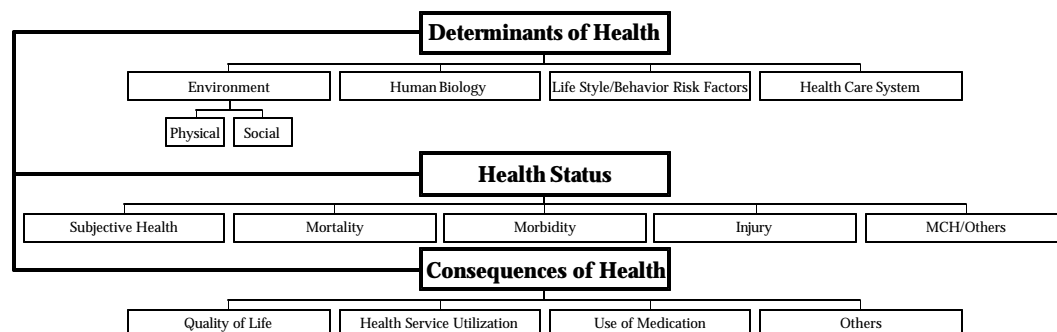


Figure 1. The MPH's Operational Model of Health

The concept of determinants of health goes beyond purely medical boundaries. It includes four major elements that contribute to health problems. They are 1) environment, 2) human biology, 3) lifestyle and behaviors, and 4) the health care system. Any health problem can be traced to one or a combination of the four elements.⁷

We have adopted this model because of its orientation toward prevention and education, and because of its flexibility. Due to constraints in the availability of data and other resources, we can only include in this report the most important indicators and those which are readily available. Since community health assessment is an ongoing process, as time goes on, and as additional data and/or other resources become available, additional community health information can be added to the future editions of *Health, Nashville, TN*.

How to Use This Report

This report is organized around the previously described health model with an emphasis on education and prevention. The report consists of five parts: introduction, determinants of health, health status, consequences of health problems, and appendices.

Individuals and organizations interested in health-related socio-economic data on Nashville will find a variety of demographic, socio-demographic, and socio-economic information under the section "Determinants of Health". The latest mortality and morbidity data and maternal and child health information is contained in the "Health Status" section. To help our readers answer the question "How is Nashville doing?", comparative data on a variety of health indicators for Nashville, Tennessee, the entire United States, and Healthy People 2010 objectives, when available, are included as well. The report is designed to serve as a comprehensive community health status information resource; therefore, a selection of raw data is also included in the appendices section for those who may need to perform their own analysis.

Neighborhood or small area data is of interest to many community members. We have made an effort to include small area data in this report. We have used Geographic Information Systems (GIS) to obtain small area data when available. Using GIS, we are able to present population data, morbidity and mortality data at the public health planning district level and at the council district level. Our goal is to eventually have all or the majority of Nashville's health status data at the public health planning district and the council district levels.

Statistics presented in this report are generally for the most recent year or period available. All data from censuses, surveys, or administrative records are subject to errors arising from a number of factors: sampling variability, reporting errors, incomplete coverage, non-responses, and processing errors. The Division of Epidemiology is responsible for the data selection, analysis, and presentation; however, we will not be responsible for the accuracy or limitations of data presented here, other than those which we collect. If we notice any accuracy or variability issues with a data source, we will be sure to bring those to the readers' attention. More information on data sources and methodological issues are detailed in the Appendix: Technical Notes.

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Suggestions and Comments

Users/readers of this report are urged to make their data needs known for consideration in planning future editions. Suggestions and comments for improving coverage and presentation of data should be sent to:

Division of Epidemiology
Metropolitan Public Health Department
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We sincerely hope that you will find this report of value to you.

This report is available at:

1. Metropolitan Public Health Department website:
<http://healthweb.nashville.org>
2. The Public Library of Nashville and Davidson County, TN

References:

1. Institute of Medicine. *The Future of Public Health*. Washington DC: National Academy Press; 1988.
2. Institute of Medicine. *Healthy Communities: New Partnerships for the Future of Public Health*. Washington DC: National Academy Press; 1996.
3. Constitution of the World Health Organization, 1948. In: *Basic Documents*. 15th ed. Geneva: WHO; 1964.
4. Regional Office for Europe WHO. *The World Health Organization: Health Promotion: Concept and Principles in Action – A Policy Framework*. 1986.
5. The National Association of County and City Health Officials and The Centers for Disease Control and Prevention. *Mobilizing for Action through Planning and Partnerships: A Community Roadmap to Health*. Washington DC; 2001.
6. Canada Health Survey, Health and Welfare Canada and Statistics Canada. *The Health of Canadians: Report of the Canada Health Survey*. Ottawa: Ministry of Supply and Services Canada; 1981.
7. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.

The mission of the Metro Public Health Department is to provide health protection, promotion, and information to everyone in Nashville so they can enjoy healthy living free from disease, injury, and disability.

Chapter Two

Determinants of Health

2.1 Environment

For the purpose of this publication, environment is defined as all those matters related to health that are external to the human body and over which the individual has little or no control. The environment consists of two parts: (1) the physical environment, and (2) the social environment.

According to Healthy People 2010, physical environment and social environment are:

Physical environment can be thought of as that which can be seen, touched, heard, smelled, and tasted. However, the physical environment also contains less tangible elements, such as radiation and ozone. The physical environment can harm individual and community health, especially when individuals and communities are exposed to toxic substances; irritants; infectious agents; and physical hazards in homes, schools, and worksites. The physical environment also can promote good health, for example, by providing clean and safe places for people to work, exercise, and play.¹

Social environment includes interactions with family, friends, coworkers, and others in the community. It also encompasses social institutions, such as law enforcement, the workplace, places of worship, and schools. Housing, public transportation, and the presence or absence of violence in the community are among other components of the social environment. The social environment has a profound effect on individual health, as well as on the health of the larger community, and is unique because of cultural customs; language; and personal, religious, or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment.¹

Because of the importance of the health care system as a health determinant, we have considered it as a separate entity from the environment in this publication. The health care system consists of the quantity, quality, arrangement, nature, and relationship of people and resources in the provision of health care. The health care system will be discussed in Section 2.3.

Reference:

1. U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition, in Two Volumes)*. Washington, D.C.: January 2000.

2.1.1 Social Environment

The social environment is increasingly recognized as associated with the overall health of a population. There is a plethora of indicators dealing with the social environment.¹ Among the elements of the social environment that have been linked to health are family structure, the educational system, social networks, social class, work setting, and level of prosperity.² Demographic data serves as a denominator for the calculation of many health related indicators since the structure and dynamics of a population are indispensable to identifying determinants of health.

References:

1. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.
2. Institute of Medicine. *Improving Health in the Community: A Role for Performance Monitoring*. Washington, D.C.: National Academy Press; 1997.

The elements of the social environment linked to health:

- family structure
- education system
- social networks
- social class
- work setting

Related Indicators

- Population distribution by age and gender
- Population density
- Race/ethnic composition of population

2.1.1.1 Population Growth Rate

Background

The population growth rate is an indicator of demographic change in a population. It reflects population shifts resulting from births, deaths, and migrations. By looking at past trends, we can make crude estimates of future changes in our community. This information helps health planners and policy makers adjust health services according to projected growth in the total population or within certain sub-groups.¹

The rate of growth is affected by differential underestimation of the population between censuses and the age structure. Growth is defined as variation, not necessarily an increase, since growth may be negative.

Findings

As shown in Figure 2, Nashville's population increased very rapidly during the 18th and 19th centuries. During the first seven decades of the 20th century Nashville maintained a 21% average growth rate. From 1960-1980, the population growth rate declined from a high of 24.2% to a low of 6.7%. The population in Nashville started to slowly increase during the 1980s and 1990s with a population growth rate of 11.6% between 1990 and 2000.

If we examine the population growth rate at the public health planning district level between 1990 and 2000, planning district 6 (Bellevue) had the highest growth rate (32.8%) while planning district 8 (North Nashville) had the lowest growth rate (-7.4%). Examining the population growth of council districts reveals that council district 31 had the highest growth rate (47.8%) while council district 17 had the lowest growth rate (-12.5%) for the same decade (Data Tables 2 and 3 in Appendix).

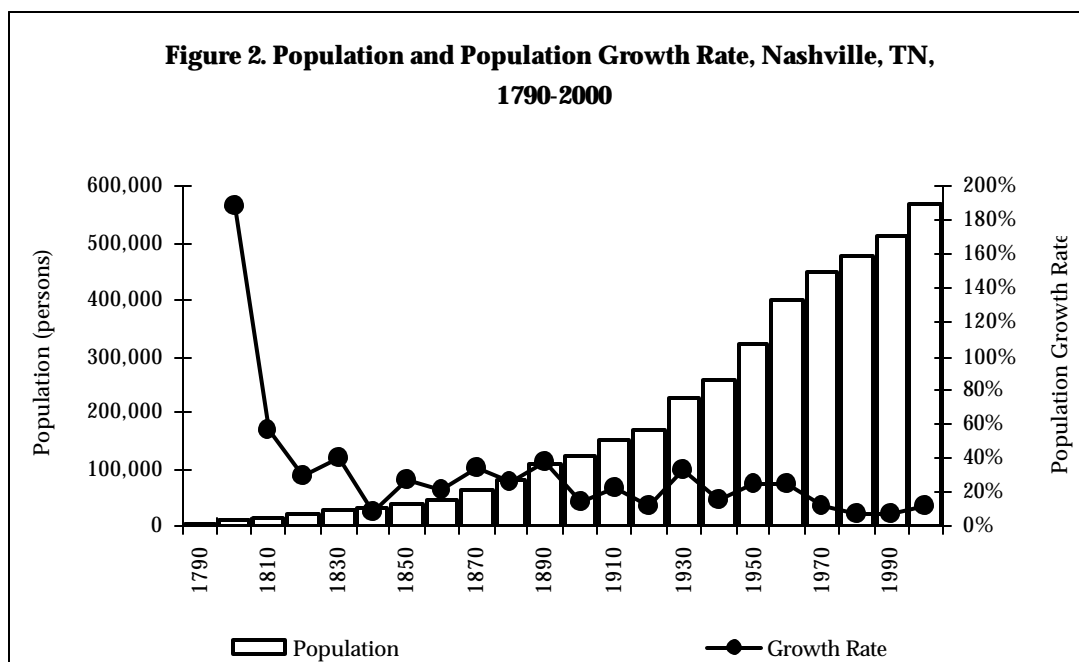
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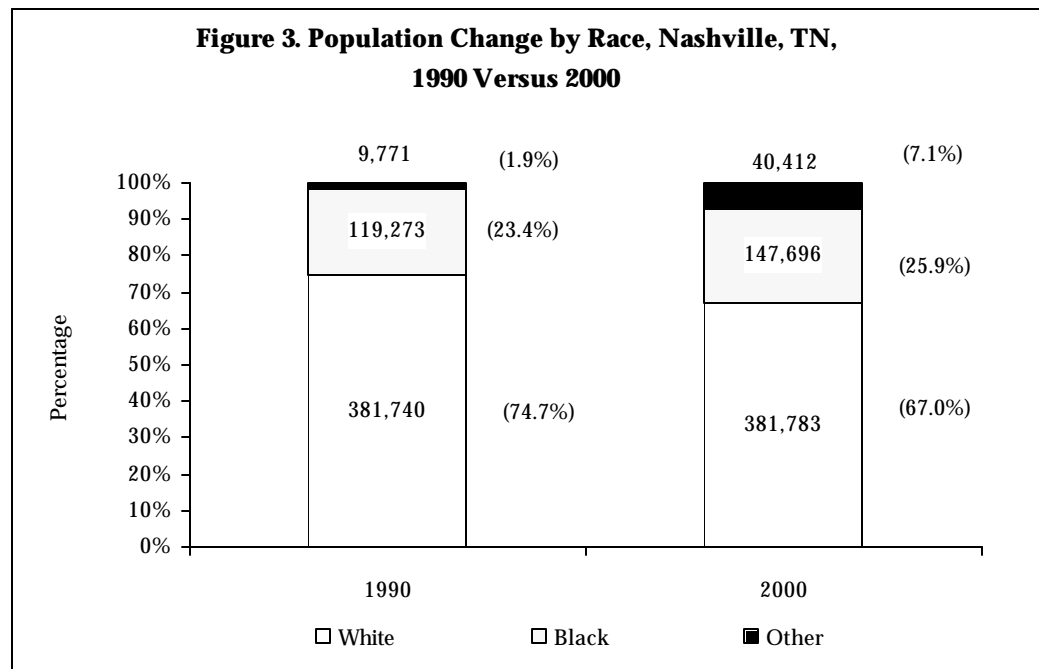
U.S. Bureau of the Census

Figure 2. Population and Population Growth Rate, Nashville, TN, 1790-2000



Nashville's population increased 11.6% from 1990 - 2000.

Figure 3 depicts Nashville's population growth during the last decade. All racial groups increased in size except for whites. The white population remained the same while minority populations increased, resulting in a more diverse population. The percentage of whites in Nashville decreased from 74.7% in 1990 to 67.0% in 2000, whereas, the black population increased from 23.4% in 1990 to 25.9% in 2000. Other races increased from 1.9% in 1990 to 7.1% in 2000, a 270.7% increase. In 2000, Hispanics made up 4.6% of the population, a 440% increase over the last decade. The number of Asian residents doubled to 2.3% (not shown in Figure 3).



With an increase in population comes an accompanying increase in population density. Nashville's population density (See 2.1.1.9 for more information.) increased 11.6% from 1016.9 persons per square mile to 1134.6 persons per square mile between 1990 and 2000.

In comparison with national and state population growth rates, the population in Nashville did not grow as fast as that of Tennessee or the entire U.S. During the last decade, the U.S. population grew 13.2% and the Tennessee population grew 16.7%. Nashville's population, however, increased only 11.6% between 1990 and 2000.

Discussion

The population in Nashville increased 11.6% during the last decade; however, this increase was smaller than increases experienced by many other counties in Tennessee. Furthermore, Nashville's population growth rate is smaller than the growth rates of both Tennessee and the United States.

During 1990 - 2000, all racial groups in Nashville increased in size except for white.

With virtually no change in the number of whites in Nashville and a significant increase in the number of non-whites between 1990 and 2000, the percentage of whites decreased and percentage of non-whites increased. This change highlighted the diversity issue. Health disparities among these groups have become an important public health issue.

Reference:

1. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.

The percentage of white population decrease and the percentage of non-white population increase from 1990 - 2000 highlights the diversity issue in our community.

Related Indicators

- Population growth rate
- Population density
- Race/ethnic composition of population

Additional Data

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2.1.1.2 Population Distribution by Age and Gender

Background

Age and gender are the basic characteristics of a population. These characteristics play a significant role in determining a community's disease spectrum and an individual's health status. Age is one of the most important factors to consider when one is describing the occurrence of health-related events because the risk of many diseases changes with age. Numerous epidemiological studies have shown gender differences in a wide scope of health phenomena. Therefore, both age and gender are essential factors to consider in the health planning process to ensure that adequate health services are provided.¹ The age and gender composition of a population can be presented as a double histogram. This double histogram is called a population pyramid, or age pyramid.

The population pyramid enables one to see the basic characteristics of the population's age and gender distribution. Any imbalances in age composition or gender distribution can easily be seen through the population pyramid. Therefore, the population pyramid is an important tool for illustrating the health portrait of a population.¹

The population pyramid can be used to compare the pyramids of two different populations or a single population at different time periods. When making comparisons, the same age groupings and the same scale should be used because different age groupings will lead to different shapes of the population pyramid. In addition, the population distribution by age and gender should be considered as a descriptor of the state of a population rather than a health indicator per se.²

Findings

Figures 4 and 5 display the age composition and gender distribution of Nashville's population in 1990 and 2000. It is observed that the overall population pyramid exhibits an upward shift. Age groups that show large increases are the 45-49 age group, the 50-54 age group, and the 85+ age group. The increases are 50.0%, 49.1%, and 32.8%, respectively. It is noted that four age groups have a negative growth rate from 1990 to 2000. They are the 65-69 age group (decreased 9.1% from 1990 to 2000), the 30-34 age group (decreased 5.6%), the 60-64 age group (decreased 3.6%), and the 25-29 age group (decreased 1.9%). (See Figure 6 and Data Tables in Appendices.)

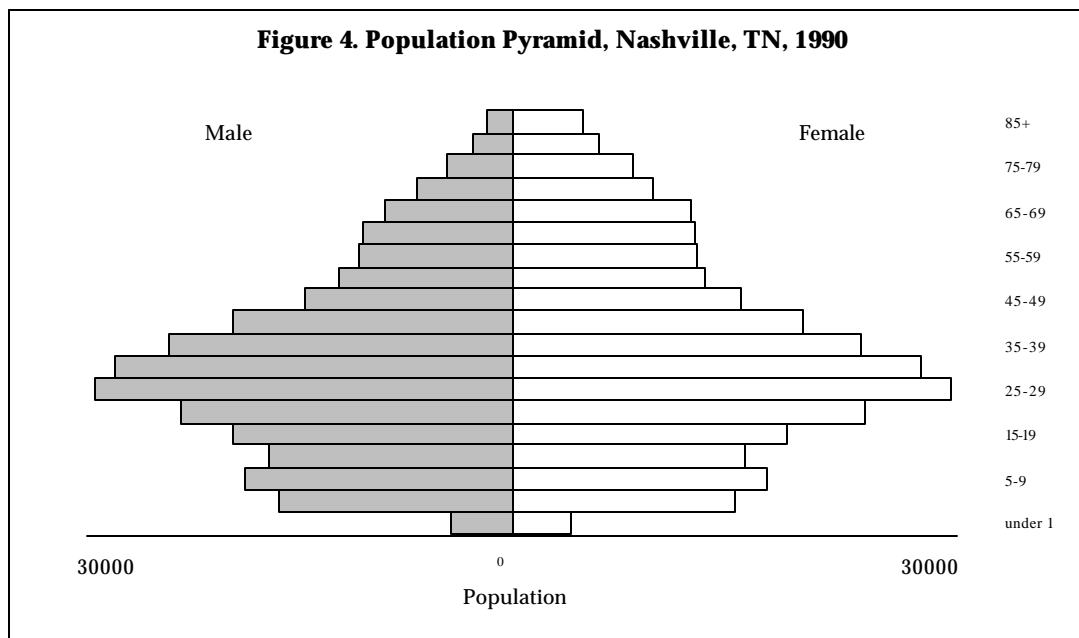
Figure 7 shows that there were more females (51.6%) than males (48.4%) in Nashville in 2000. Additionally, the percentage of females in the population decreased 1.8% from 1990 to 2000.

Discussion

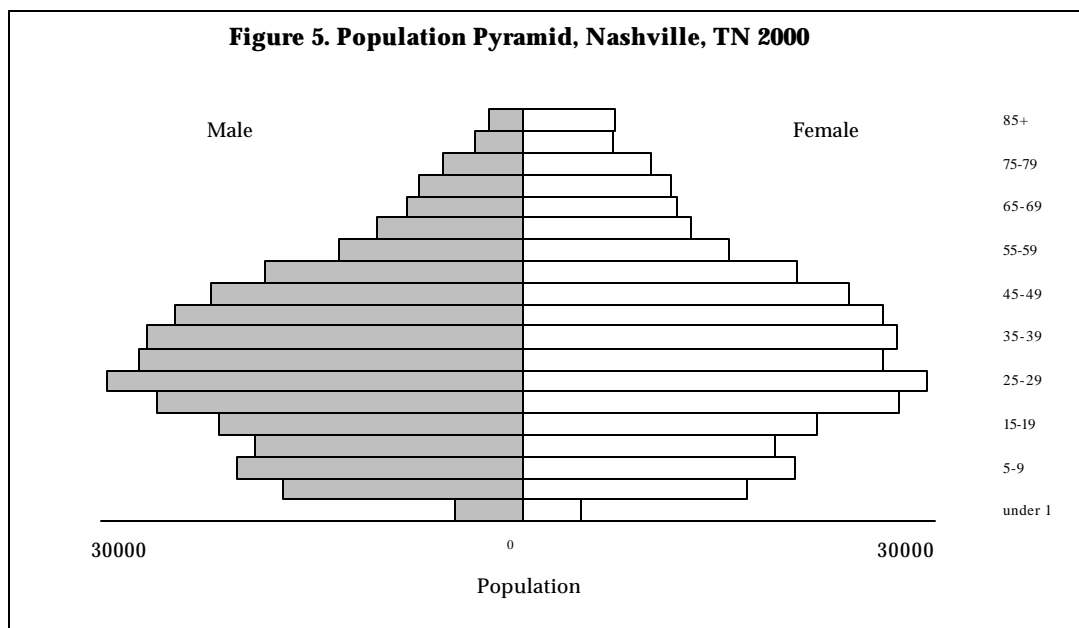
The upward movement of Nashville's population pyramid and the large increases in the age groups 45-49, 50-54, and 85+ presents two new challenges to our community. Nashville's population reflects the aging trend of the nation's population; however, the 45-54 age group and the 85+ age group will have different health needs. The 45-54 age group is often referred to as "middle aged". For some it may be a time of slowing down, planning for retirement, and paying more attention to health. Nashville's population increase in this age group is paralleled nationally as the "baby boomers" begin their second 50 years of life. It is during this time period that cancer becomes a more feared and real threat for an individual. In Nashville, for both genders, increases

Data Sources

U.S. Bureau of the
Census

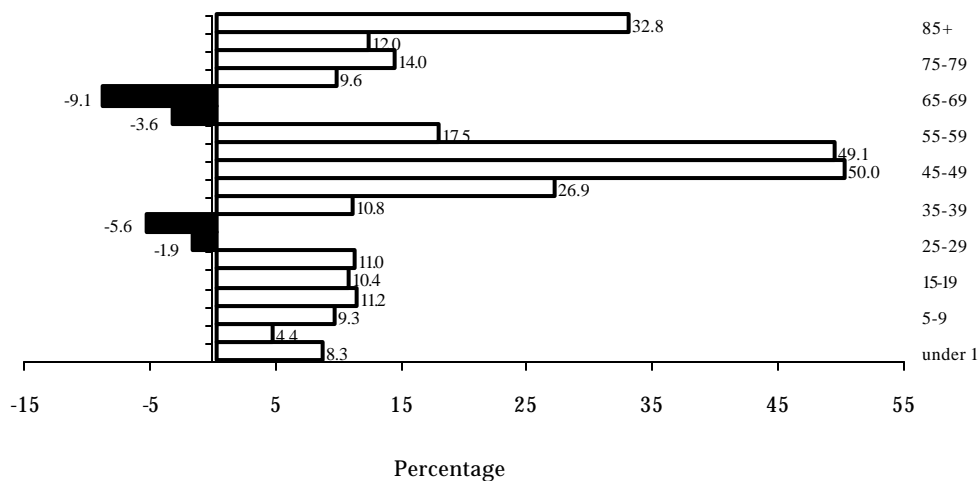
Figure 4. Population Pyramid, Nashville, TN, 1990

The upward movement of Nashville's population pyramid and large increases in the age groups of 45 - 49, 50 - 54, and 85+ present two new challenges to our community.

Figure 5. Population Pyramid, Nashville, TN 2000

in cancer deaths begin in the 35-44 age group and speed up in the 45-54 age group.³ Heart disease and stroke as leading killers become a reality for the 45-54 age group.³ The good news is that the three leading killers for these people aged 45-54 are preventable, wholly or in part, through changes in behavior and lifestyle. For ages 85+, the major challenge will be to ensure a high quality of life during the "golden years". Chronic problems such as arthritis, osteoporosis, incontinence, visual and hearing impairments, and dementia are major concerns because they impair day-to-day living. Adopting a healthy lifestyle and making health services available and accessible to this group should be on the health planner's agenda.

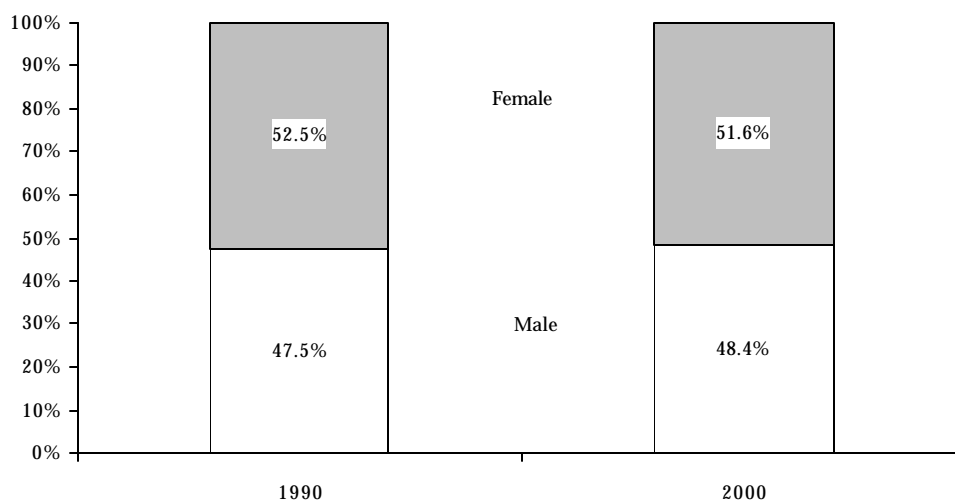
Figure 6. Population Percentage Change by Age Group, Nashville, TN, 1990 and 2000



Four age groups had a negative growth rate from 1990 - 2000:

65 - 69
30 - 34
60 - 64
25 - 29

Figure 7. Population Gender Distribution, Nashville, TN, 1990 and 2000



References:

1. Peron Y, Strohmenger C. *Demographic and Health Indicators*. Statistics Canada; 1985.
2. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.
3. Division of Epidemiology, Metropolitan Public Health Department of Nashville and Davidson County. *1997 Mortality Assessment, Davidson County, TN*. 1999.

Related Indicators

- Population growth rate
- Population density
- Population distribution by age and gender

Additional Data

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2.1.1.3 Race/Ethnic Composition of Population

Background

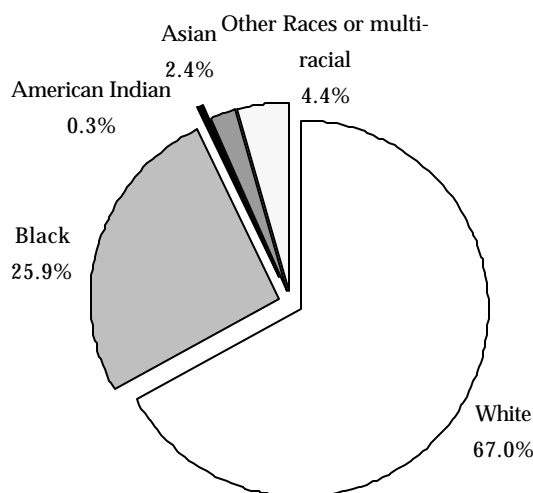
Race is a biological designation whereby group members share distinguishing features such as skin color, bone structure, and genetic traits. It is primarily a social classification that relies on physical attributes to identify group membership.¹ Ethnicity is the shared feeling of peoplehood among a group of individuals. Ethnicity represents the identifying characteristics of culture, such as race, religion, or national origin.² Whether representing actual differences or a constellation of factors that affects health and health status, race, and ethnicity are important determinants of health patterns in the United States.³ Different race/ethnic groups may have different demographic, social, economic, and health characteristics. Understanding the race/ethnic composition in our community is crucial in planning, programming, and delivering health services to a culturally and ethnically diversified population.

Race and ethnicity are, to some extent, ambiguous characteristics that tend to overlap with nativity and religion. Some studies treat race as synonymous with ethnicity because people who come from a particular racial group may also have a common ethnic and cultural identification.⁴ Other researchers have even proposed to abandon “race” as a variable in public health research.¹

Findings

Figure 8 displays the racial distribution of Nashville's population. In 2000, whites accounted for 67.0% of the population while blacks made up 25.9%. Asians accounted for 2.4%, American Indians accounted for 0.3%, and other races and multiple races made up 4.4% of population (Data Tables in Appendices).

Figure 8. Population's Racial Distribution, Nashville, TN, 2000

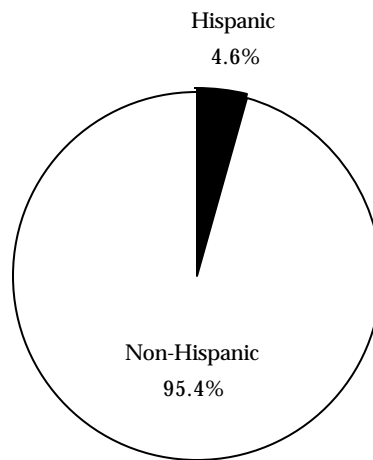


Data Sources

U.S. Bureau of the Census

Figure 9 displays the ethnic distribution of Nashville's population. In 2000, Hispanics accounted for 4.6% of the population while non-Hispanics made up 95.4% of the population.

Figure 9. Population's Ethnic Distribution, Nashville, TN, 2000



Race/ethnic groups may have different demographics, social, economic, and health characteristics.

Figure 10. Racial and Ethnic Distribution, Nashville, Tennessee, and U.S., 2000

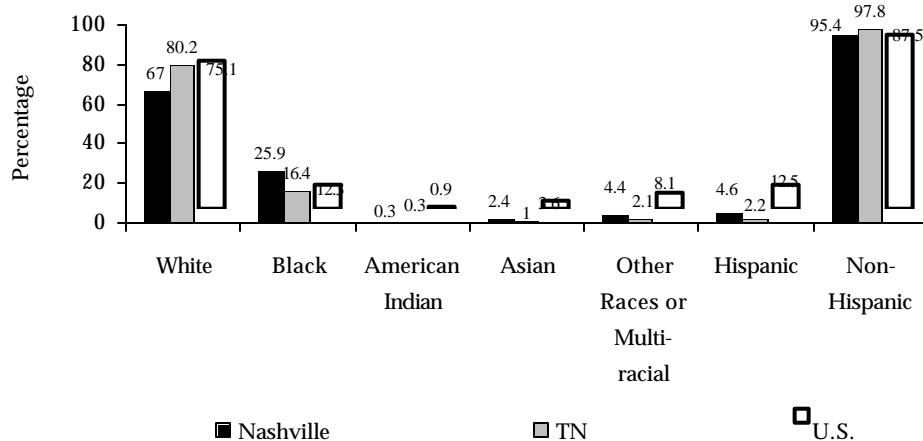


Figure 10 shows a comparison of the racial and ethnic distributions of the populations in Nashville, Tennessee, and the United States in 2000. Nashville had a higher percentage of blacks and lower percentage of whites than Tennessee or the United States. The percentage of Asians in Nashville is more than twice as high as that of Tennessee but only two thirds of that of the United States. Ethnically, the percentage of Hispanics in Nashville is more than twice as high as that of Tennessee, but less than half of the nation's Hispanic population.

Discussion

As Mayor Bill Purcell pointed out, the percentage decrease of whites and the percentage increase of nonwhites “highlight the need to address diversity, as well as specific language issues.”⁵ With a more diversified population in Nashville, the health care system will face the challenges of setting health priorities to address issues such as cultural competency among health care providers and racial and ethnic health disparities among Nashville residents.

References:

1. Bhopal R, Donaldson L. White, european, western, caucasian, or what? inappropriate labeling in research on race, ethnicity, and health. *American Journal of Public Health*. 1998;88(9).
2. Stanhope M, Lancaster J. *Community and Public Health Nursing*. St. Louis: Mosby; 1996.
3. Sondik EJ, Lucas JW, et al. Race/ethnicity and the 2000 census: implications for public health. *American Journal of Public Health*. 2000;90(11).
4. Friss, RH, Sellers, TA. *Epidemiology for Public Health Practice*. 2nd Edition. Gaithersburg, MD: Aspen Publishers, Inc; 1999.
5. Wadhwani A. Davidson: nonwhite population growth highlights diversity issue. *Tennessean*. 12A, March 23, 2001.

In 2000, Nashville had a higher percentage of blacks and a lower percentage of whites than Tennessee and the United States.

Related Indicators

- Unemployment
- Poverty levels
- Income
- Single parent family
- Non-English speaking population
- Health status

Additional Data

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Data Sources

U.S. Bureau of the
Census

2.1.1.4 Educational Attainment (Persons 25 years and Over)

Background

Education is a widely used indicator of socioeconomic status in the United States. Education impacts health through a variety of cultural, social, and psychological mechanisms and is related to its influence on individuals' earning power and health related values such as a belief in disease prevention.¹ The number of years of formal education has been shown to be strongly related to age-adjusted mortality in six different countries.² In addition, a mother's educational attainment is a key determinant of child welfare and survival.³

The average level of education in the U.S. population has increased steadily over the past several decades. Higher levels of education may increase the likelihood of obtaining or understanding the health-related information needed to develop health-promoting behaviors and beliefs in prevention.⁴ Higher levels of education appear to be the strongest and most important predictor of positive health status.⁵

Educational attainment information for the residents of Nashville is obtained from the Census 1990 and Census 2000 data. It is noted that the Census undercounts some groups, such as the homeless and young adults. In addition, some people are not counted while others are counted more than once. It is also noted that comparisons between censuses are affected by changes in question wording and in the definition of the population concerned. The age structure of the population may influence the indicator: an older population, for instance, generally has lower education levels than a younger population due to improved access to education over time.⁶

Findings

From Figure 11, it is clear that during the last decade, Nashvillians made progress in educational attainment. For individuals aged 25 and over, the percentage of those who have less than a high school diploma decreased from 24.1% in 1990 to 18.4% in 2000, while the percentage of those who have a bachelor's degree and higher increased from 24.4% in 1990 to 30.5% in 2000.

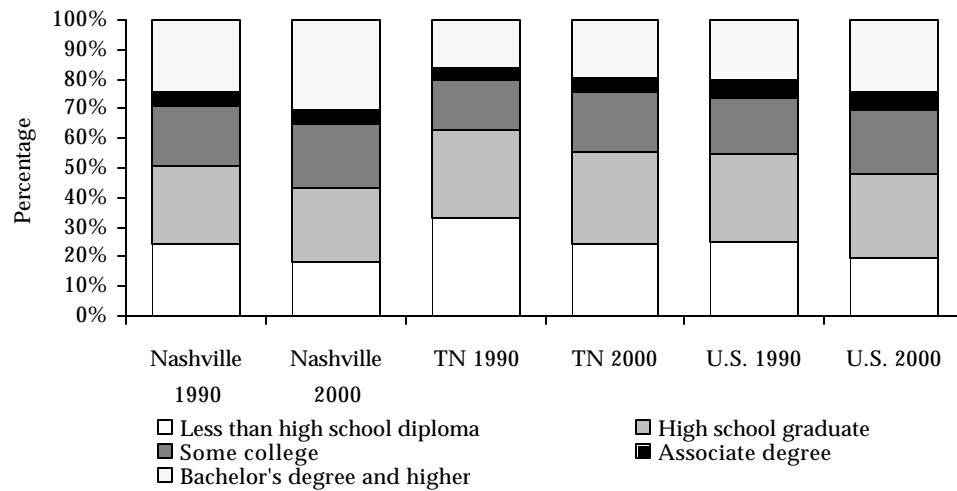
Figure 11 also displays that more than half of Nashville's population received some form of higher education in 2000 (some college, associate degree, and bachelor's degree and higher, (56.9%), which is a higher percentage than that of Tennessee (44.3%) and of the United States (51.7%).

Discussion

Nashville has a relatively higher proportion of educated people than Tennessee and the United States. This is good news for the public health community in terms of mobilizing our community for action through planning and partnership to promote health and to control diseases. The challenge is how to use this invaluable community asset to optimize Nashville's environment so that all Nashvillians can be healthy.

Nashville has a relatively higher proportion of educated people than Tennessee and the United States.

Figure 11. Distribution of Educational Attainment in Persons 25 Years and Over, Nashville, Tennessee, and U.S., 1990 and 2000



References:

1. Pamuk ER, Makuc DM, et al. *Socioeconomic Status and Health Chartbook. Health, United States, 1998*. Hyattsville, MD: National Center for Health Statistics; 1998.
2. Valkonen, T. Adult mortality and level of education: a comparison of six countries. In: J. Fox, ed. *Health Inequalities in European Countries*. Aldershot, England: Gower; 1989.
3. Zill, N. II, Brim, O.G., Jr. Development of childhood social indicators. In: E.F. Zigler, S.L.Kegan, and E. Klugman, eds. *Children, Families, and Government: Perspectives on American Social Policy*. New York: Cambridge University Press; 1983.
4. U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, in Two Volumes). Washington, D.C.: January 2000.
5. Winkelby MA, Jatulis DE, et al. Socioeconomic status and health: how education, income, and occupation contribute to risk factors for cardiovascular disease. *Am. J. Public Health*. 1992;82:816-820.
6. Association of Public Health Epidemiologists in Ontario. *Core Population Health Indicators for Ontario* [online]. Available at: <http://www.cehip.org/apheo/>. Accessed March 26, 2002.

Higher levels of education appear to be the strongest predictor of positive health status.

Related Indicators

- Poverty level
- Income
- Single parent family
- Non-English speaking population
- Educational attainment
- Health status

Additional Data

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Data Sources

U.S. Bureau of the
Census
Nashville Area Chamber
of Commerce

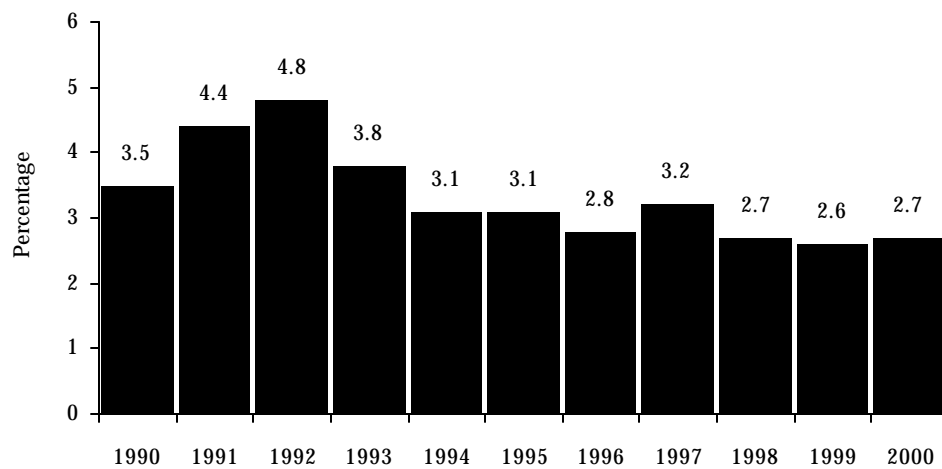
2.1.1.5 Unemployment

Background

Unemployment is frequently used as an indicator of socially disadvantaged status. It may be associated with increasingly difficult living conditions, low socioeconomic status, and health and social problems.¹ According to the official measure used in the United States, the unemployment rate is the number of people who have been recently seeking work divided by the number of people who are in the labor force.² Numerous studies document the relationship between unemployment and health. A longitudinal study in the United Kingdom found excess mortality among the unemployed and suggests that unemployment may cause socio-economic hardship and stress which can lead to negative health consequences.³ A study on a Swedish plant closure reported evidence for consistent increases in cholesterol and decreased immune reactions among those who were laid off.² Unemployment has also been associated with an increase in unhealthy behaviors such as alcohol and tobacco consumption, which may lead to increased risk for disease, injury, and death.²

Tennessee's unemployment figures are based on two surveys, the Current Population Survey and the Business Survey.⁴ Each month, the Federal Bureau of Labor Statistics randomly surveys sixty thousand individuals around the nation. If respondents say they are both out of work and seeking employment, they are counted as unemployed members of the labor force. Jobless respondents who have chosen not to continue looking for work are considered out of the labor force and are therefore, not counted as unemployed.⁵ Since the unemployment rate does not take into account persons who have stopped actively looking for a job, it may underestimate the true unemployment situation.⁶ In addition, there is an acceptable low level of unemployment. In the early 1960s, an unemployment rate of 4 percent was both desirable and achievable, i.e., full employment was considered to exist.^{5,7}

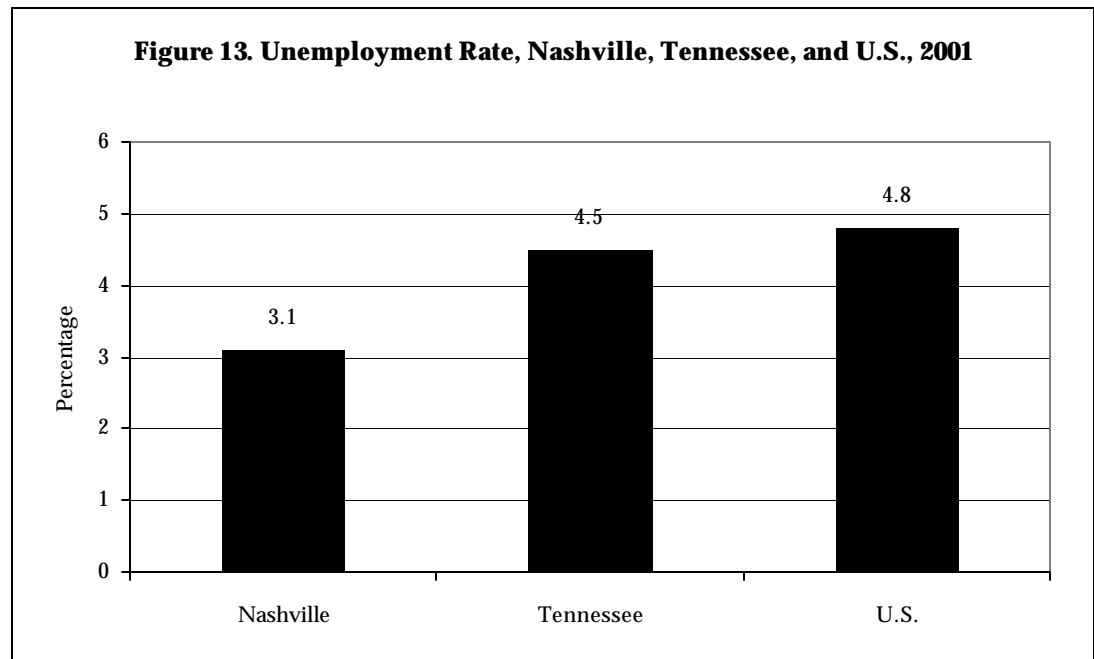
Figure 12. Unemployment Rates, Nashville, TN, 1990-2000



Findings

Figure 12 reveals the trend of unemployment in Nashville, TN from 1990 to 2000. During the 11-year period examined, only two years in the early 1990s (1991 and 1992) had unemployment rates higher than 4%. Beginning in 1993, Nashville had a continuous low unemployment rate for 8 years.

If we compare the 2001 unemployment rate of Nashville with that of Tennessee and the United States, it seems clear that Nashville has the lowest unemployment rate of the three (Figure 13).



Discussion

Low unemployment rates in Nashville for most of the last decade indicate that our community is healthy and economically viable. Since no data is available regarding the unemployment situation among sub-population groups in our community, further study is needed to see if unemployment is contributing to our community's racial disparity in health.

In 2001, Nashville had a lower unemployment rate than Tennessee and the United States.

References:

1. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.
2. Dooley D, Fielding J, Levi L. Health and unemployment. *Annu.Rev. Public Health*. 1996;17:449-65.
3. Detels R, Holland WW, et al. *Oxford Textbook of Public Health*. 3rd ed. New York: Oxford University Press; 1997.
4. Tennessee Department of Labor and Workforce Development. Available at: <http://www.state.tn.us/labor-wfd/news/marchstate2002.pdf>. Accessed March 28, 2002.
5. Summers LH. Unemployment, the concise encyclopedia of economics [online]. Available at: <http://www.econlib.org/library/Enc/Unemployment.html>. Accessed March 28, 2002.
6. Association of Public Health Epidemiologists in Ontario. Core population health indicators for ontario [online]. Available at: <http://www.cehip.org/apheo>. Accessed March 26, 2002.
7. Nashville Area Chamber of Commerce. *1998 Guide for Community Improvement*. 1999.

The unemployment rate is the measure of people who have been recently seeking work divided by the number of people who are in the labor force.

Related Indicators

- Unemployment
- Income
- Single parent family
- Non-English speaking population
- Educational attainment
- Health status

2.1.1.6. Poverty Level

Background

Poverty is defined as having insufficient financial resources to meet basic living expenses. These expenses include costs of food, shelter, clothing, transportation, and medical care. For years, income level has been used as the criterion to determine poverty status.¹ The U.S. Census Bureau uses a set of income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than the calculated threshold, then that family, and every individual in it, is considered poor.² While income continues to be the measurement of choice, the federal poverty guidelines have been renamed "federal income guidelines."¹

Poverty is known to be associated with poor health. Persons living in poverty and near-poverty have higher rates of chronic diseases, higher infant morbidity and mortality, shorter life expectancy, and more complex health problems. These poor health outcomes are often secondary to inadequate access to health care.¹ The poverty level is a useful indicator to enable us to identify groups at risk for specific health problems such as malnutrition or poor housing conditions and to plan for health services for economically disadvantaged sub-populations.³

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There is an arbitrary element in the criteria used to determine poverty levels. Although living expenses vary from one area to another the poverty thresholds do not vary geographically.² In addition, the poverty level does not consider the near-poor or low wage-earners who have incomes barely above the poverty level and who might have living conditions similar to persons below the poverty line.³ It should be noted that poverty level is the cut-off point for the financial resources necessary for basic material survival. It is not an indicator of general welfare and gives no information on the intensity or the duration of poverty.³

Findings

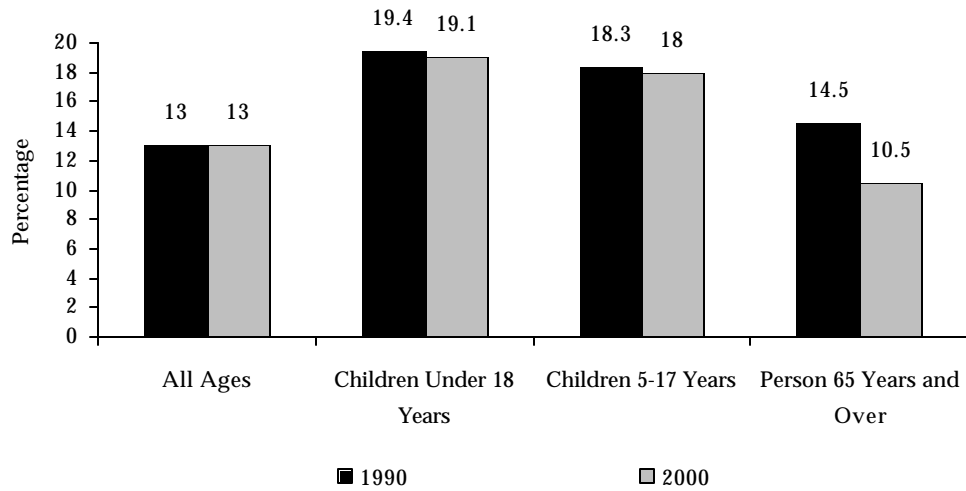
Figure 14 compares the percentages of individuals below the poverty level in Nashville, TN for 1990 and 2000. Overall, the percentage of the population below the poverty level did not change during the last decade. The percentage of children under 18 years of age and children between the ages of 5 to 17 below the poverty level decreased slightly (from 19.4% to 19.1% and from 18.3% to 18.0%, respectively). However, the percentage of persons ages 65 and over below the poverty level decreased remarkably, from 14.5% to 10.5%.

Figure 15 compares the percentages of individuals below the poverty level in Nashville with that of Tennessee and the United States. Overall, Nashville has fewer individuals below the poverty level compared to Tennessee and more individuals below the poverty level compared to the United States proportionally. For children under 18 years of age and children 5 - 17 years of age, Nashville has a larger percentage of persons below poverty level compared to Tennessee and the United States. For persons 65 years and older, Nashville's percentage is better than Tennessee and worse than the nation. For families with a female householder, no husband present, Nashville has a smaller percentage of persons below poverty level compared to Tennessee and a larger percentage compared to the nation.

Data Sources

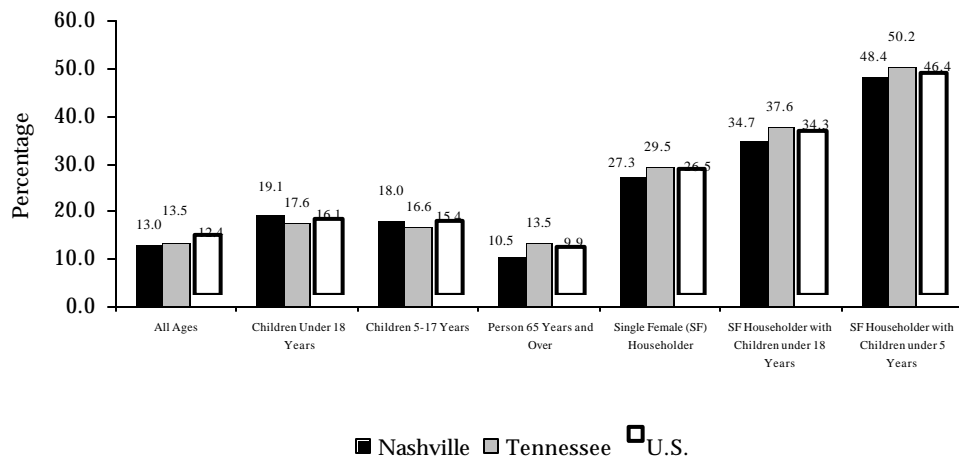
U.S. Bureau of the Census

Figure 14. Percentage of the Population Below the Poverty Level, Nashville, TN, 1990 and 2000



The fact that relatively higher percentages of elderly people live below the poverty level in Nashville presents a challenge to our community.

Figure 15. Percentage of Persons Below the Poverty Level, Nashville, Tennessee, U.S., 2000



Discussion

Poverty is associated with poor health. The fact that relatively higher percentages of elderly people live below the poverty level in Nashville presents a challenge to our community. The major causes of death among Nashvillians aged 65 and over are heart disease, cancer, and stroke. ⁴ Many cases of these diseases are preventable, or at least partially preventable. Poverty is one of the risk factors that needs to be addressed in order to prevent these diseases and to ensure a high quality of life among our senior citizens.

The higher percentage of single female householders with children under 18 years of age and under 5 years of age below the poverty level in Nashville calls upon us to enhance our maternal and child health services. (See more discussion in Section 2.1.1.8.) It is important to ensure at the community level that primary and preventive health care is available and accessible to all children regardless of their economic status.

References:

1. Stanhope M, Lancaster J. *Community and Public Health Nursing*. St. Louis: Mosby; 1996.
2. U.S. Census Bureau. How the census bureau measures poverty [online]. Available at: <http://www.census.gov/prod/2001pubs/p60-214.pdf>. Accessed April 1, 2002.
3. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.
4. Division of Epidemiology, Metropolitan Public Health Department of Nashville and Davidson County. *1997 Mortality Assessment, Davidson County, TN*. 1999.

The higher percentage of single female householders with children under 18 years of age and under 5 years of age below the poverty level in Nashville calls upon us to enhance our maternal and child health services.

Related Indicators

- Unemployment
- Poverty level
- Single parent family
- Educational attainment
- Health status

2.1.1.7. Income

Background

Income, along with education, form the two main indicators of socioeconomic status. Income is related to many health indicators. Adults with low incomes are far more likely than those with higher incomes to report fair or poor health status. Individuals with low family income are less likely to have health insurance coverage than higher income individuals. Children in lower income families are less likely to receive needed health care. Overweight is inversely related to family income.¹

There are several indicators to measure income. Median household income and per capita income are frequently used as income indicators. Median household income is defined by the U.S. Census Bureau as the amount which divides the household income distribution into two equal groups, half with incomes above the median, and half with incomes below the median. The medians are based on people age 15 years and older with income. Per capita income is defined as the average income computed for every man, woman, and child in a particular group. The Census Bureau derives per capita income by dividing the total income of a particular group by the total population in that group (excluding patients or inmates in institutional quarters).²

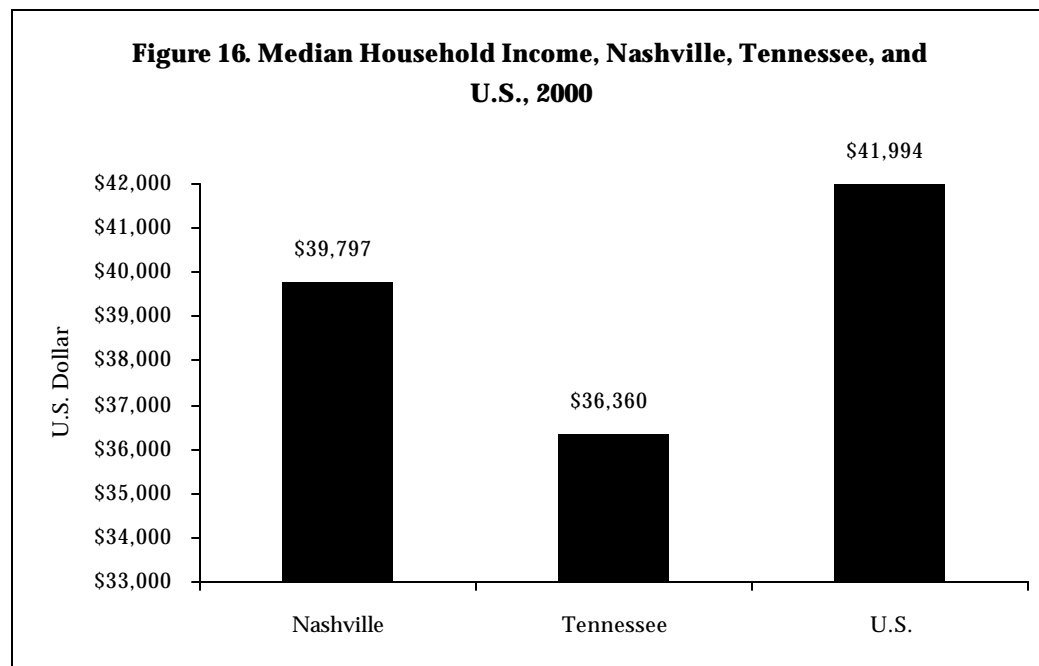
Additional Data

Appendices
page D-24

Household income is influenced by the number of earners per household. Inflation is often a significant component of apparent growth in any series measured in dollars. The data presented here is in both “current dollars” and “constant dollars,” or inflation adjusted dollars (2000\$).³

Findings

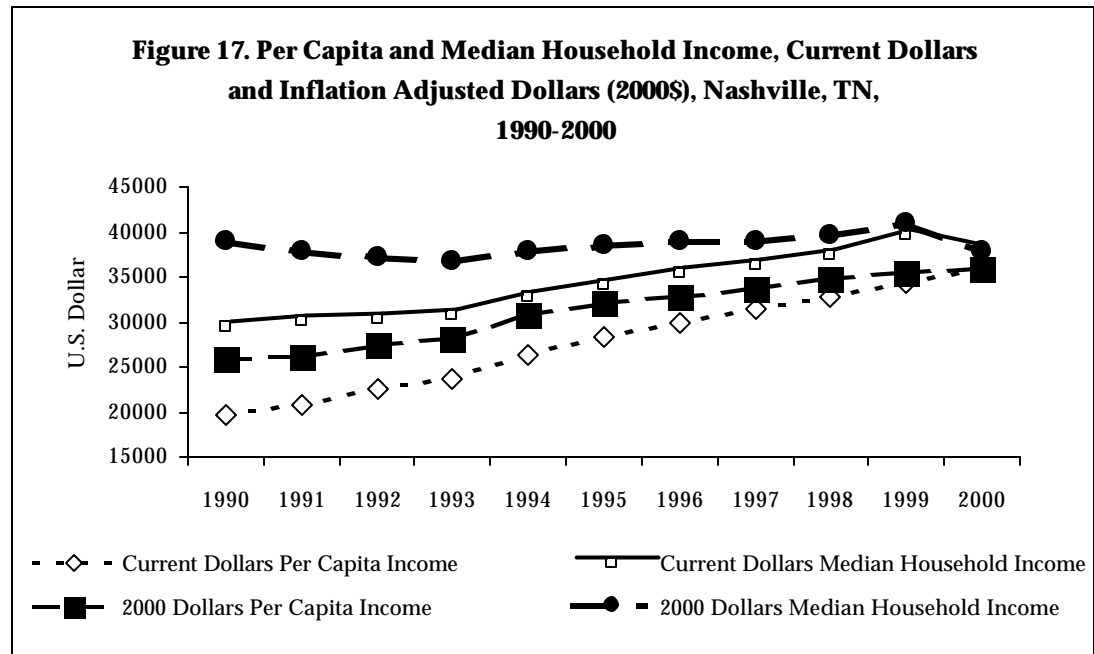
Based on the U.S. Census Bureau 2000 Census data, Nashville’s median household income is higher than that of Tennessee and lower than that of the United States (Figure 16).



Data Sources

Nashville Area Chamber
of Commerce
U.S. Bureau of the
Census

Figure 17 displays the income trend data for Nashville. (The data is from the Nashville Area Chamber of Commerce.⁴) The data suggests that the per capita income increased steadily regardless of whether or not it was measured by current dollars or inflation adjusted dollars. For median household income, the current dollar measure indicates an increasing trend except for the year 2000. Whereas, inflation adjusted dollar (2000\$) measures display a flat line, suggesting little change in median household income during the last decade.



Income inequality in the United States increased during the last three decades.

Discussion

Income inequality in the United States increased during the last three decades.¹ Although no local data is currently available to assess the income inequality issue in our community, an increase in per capita income and virtually no-change in median household income during the last decade may suggest increased income inequality in Nashville.

Income inequality may have some negative impacts on the health of the community. The association between income and health may be due to the influence of income on access to medical care, choice of neighborhoods and housing, and engagement in health-promoting behaviors. Inversely, poor health can have negative impact on income. For example, poor health may restrict the type or amount of employment or prevent an individual from working full-time.¹

References:

1. Pamuk ER, Makuc DM, et al. *Socioeconomic Status and Health Chartbook. Health, United States, 1998*. Hyattsville, MD: National Center for Health Statistics; 1998.
2. U.S. Census Bureau. Available at: <http://www.census.gov/population/www/cps/cpsdef.html>. Accessed March 22, 2002.
3. American Institute of Economic Research. Cost of living calculation [online]. Available at: <http://www.aier.org/cgi-bin/colcalculator.cgi>. Accessed March 25, 2002.
4. Nashville Area Chamber of Commerce. *2000 Guide to Community Improvement Overview*. 2002.

Related Indicators

- Unemployment
- Income
- Poverty level
- Educational attainment
- Health status

2.1.1.8 Single Parent Family

Background

The family can influence an individual's concept of health and illness by providing an environment that affects health values, health habits, health risk perception, and health care seeking behavior.¹ A stable family is one of the essential factors in the healthy development of a child.² The family structure plays a critical role in influencing health. The traditional nuclear family of married couples and the proportion of children living with two parents has decreased, while the number of single parent families has increased since 1960.²

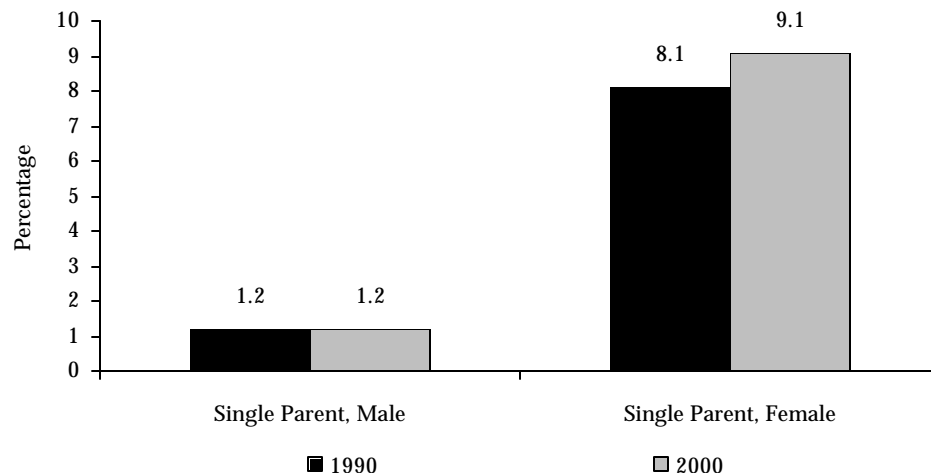
Single parent families have become an important type of American family structure that has a significant impact on individual and community health. The single parent family may be represented by the persons who voluntarily never married with biological or adopted children, other persons who involuntarily never married with children, the formerly married widow with children, or the divorced parent with children.¹ In the United States, single mothers are six times more likely than single fathers to be raising children, and the percentage of single mothers below the poverty level is higher than that of married couples. Furthermore, a higher proportion of black and Hispanic female-headed households are below the poverty level.^{1,3} Therefore, single parent families are an important indicator in assessing the impact of family structure changes upon the health status of family and the community.

Additional Data

Appendices
page D-24

It is important to note that a family, according to the U.S. Census Bureau, is a group of two or more people (one of whom is the householder) who are related by birth, marriage, or adoption and reside together; all such people (including related subfamily members) are considered members of one family. The number of families is equal to the number of family households. Beginning in 1980, the Bureau of the Census replaced the terms "head of household" and "head of family" with the terms "householder" and "family householder."⁴

Figure 18. Percentage of Single Parent Households with Children under 18, Nashville, TN, 1990 and 2000



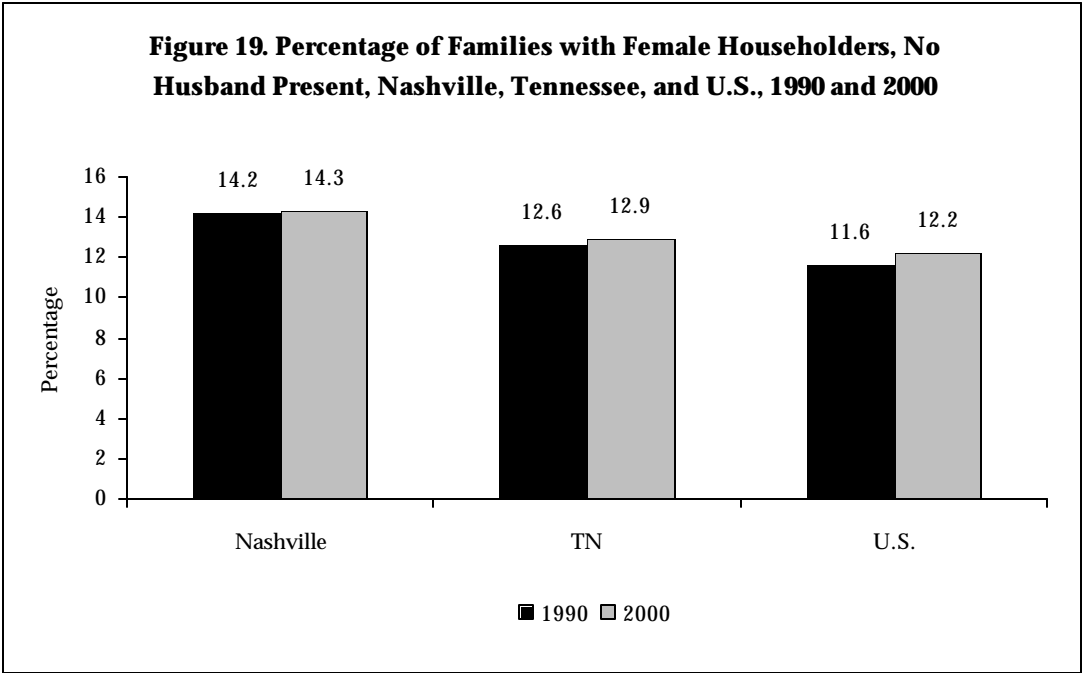
Data Sources

U.S. Bureau of the
Census

Findings

Figure 18 reveals that from 1990 to 2000 the percentage of single father families with children under 18 remained the same while the percentage of single mother families increased by 12.3%.

Figure 19 compares the percentage of families with female householder and no husband present in Nashville, Tennessee, and the United States. In both 1990 and 2000, Nashville had a higher percentage of female-headed families than Tennessee and the United States. The percentage of families with female householder in Nashville increased slightly from 1990 to 2000.



In both 1990 and 2000, Nashville had a higher percentage of female-headed families than Tennessee and the United States.

Discussion

Single parents, especially single mothers, bear both responsibilities of home and job. These overburdening responsibilities often create a lot of stress. Stress and feelings of isolation may lead to depression.¹ With nearly one tenth (9.1%) of the families in Nashville being single mother families, the importance of social networks comprised of family, friends, and mental health services cannot be overemphasized.

Although single parent families are gaining more acceptance today, they still represent a deviation from the highly valued nuclear family norm.⁵ Single parent families experience higher levels of stress and greater than average demands for mental health services and child health services.¹ It is important to remember this special population in our community when planning for mental health and child health services.

References:

1. Stanhope M, Lancaster J. *Community and Public Health Nursing*. 5th Ed. St. Louis: Mosby; 2000.
2. Kotch JB, ed. *Maternal and Child Health: Programs, Problems, and Policy in Public Health*. Gaithersburg, MD: Aspen Publishers, Inc; 1997.
3. U.S. Department of Health and Human Services. *Health Status of the Disadvantaged: Chartbook 1990*.
4. U.S. Census Bureau. Current population survey (CPS) - definitions and explanations [online]. Available at: <http://www.census.gov/population/www/cps/cpsdef.html>. Accessed April 9, 2002.
5. Gilliss CL, Highley Bland, et al. *Toward a Science of Family Nursing*. Menlo Park, CA: Addison-Wisley Publishing Company; 1989.

With nearly one tenth (9.1%) of the families in Nashville being single mother families, the importance of social networks comprised of family, friends, and mental health services cannot be overemphasized.

Related Indicators

- Population growth rate
- Population distribution by age and gender
- Race/ethnic composition of population

Additional Data

Appendices
pages D-27 - 28

Data Sources

U.S. Bureau of the Census
Metropolitan Planning
Commission

2.1.1.9 Population Density

Background

Population density is a demographic indicator that will enable us to acquire a good understanding of the population in a community and how it is changing. It provides useful information for health service planning and targeted public health intervention. Population density is commonly presented as the number of persons per square mile, calculated by the total population divided by land area in square miles. Density can be calculated for any area and any sub-population.

It is common to associate the concept of a population with the total population; however, sub-population or neighborhood data are often more valuable for addressing community concerns.¹ For this reason, we present population density data at the county, planning district, and council district levels. We also present population density data by different sub-population groups. Since populations and sub-populations are not homogeneous in regard to health issues, and they are not equally distributed in a specific land area, population density data should be used with caution.

Findings

Figure 20 shows that Nashville has a higher population density when compared with that of Tennessee and the United States.

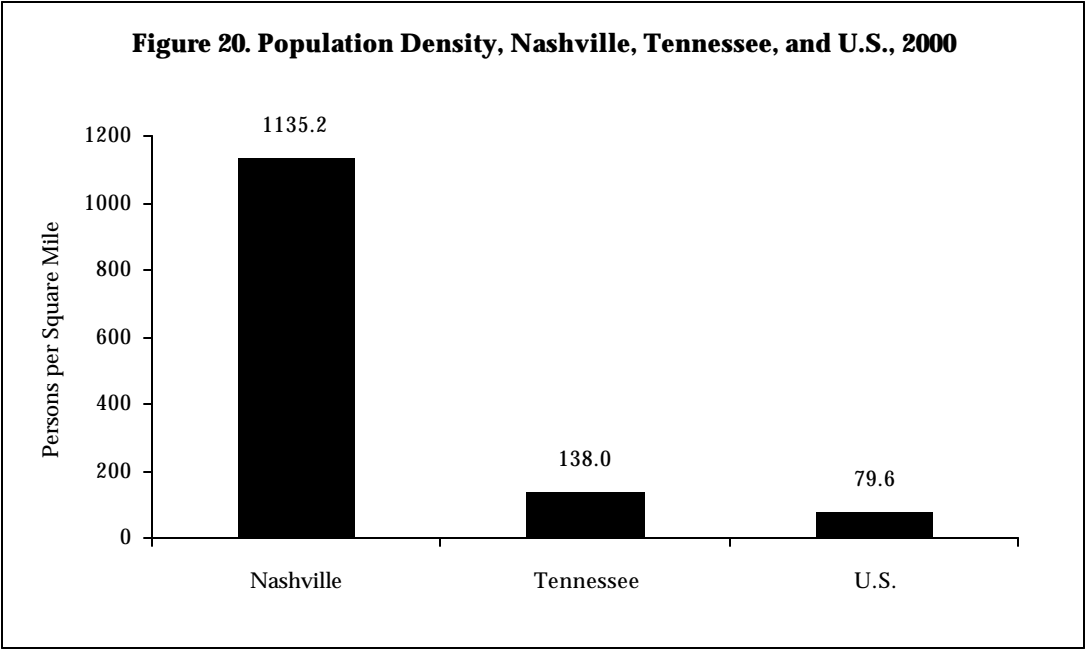
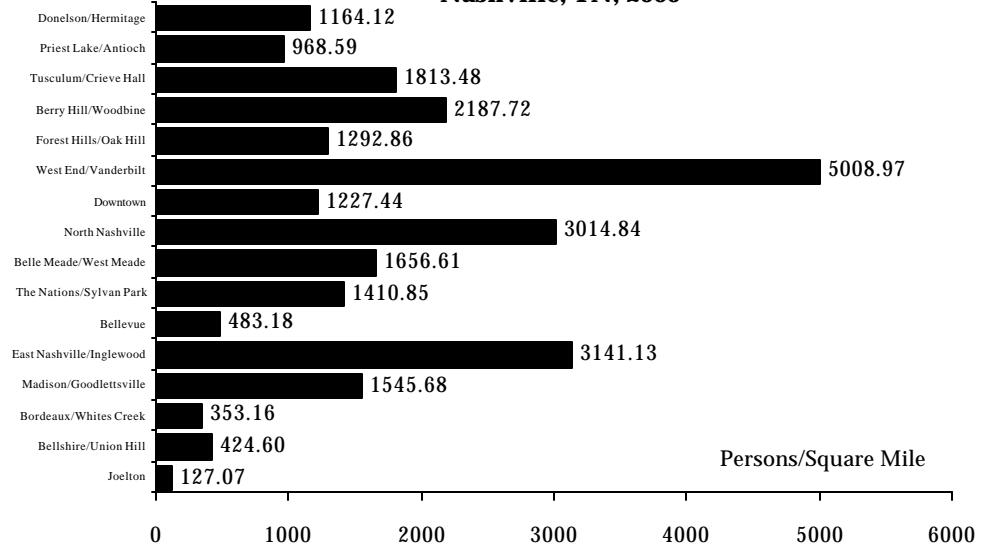


Figure 21 reveals population density by planning district. Planning district 10a (West End/Vanderbilt) is the most dense district while planning district 1 (Joelton) is the least dense district.

Figure 21. Population Density by Health Planning District, Nashville, TN, 2000



Population density is commonly presented as the number of persons per square mile, calculated by the total population divided by land area in square miles.

Figure 22. Population Density by Council District (1991-2002), Nashville, TN, 2000

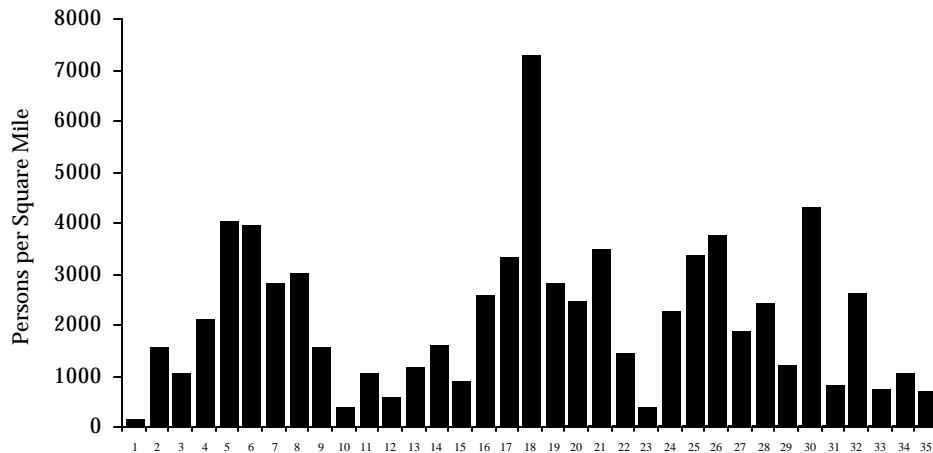
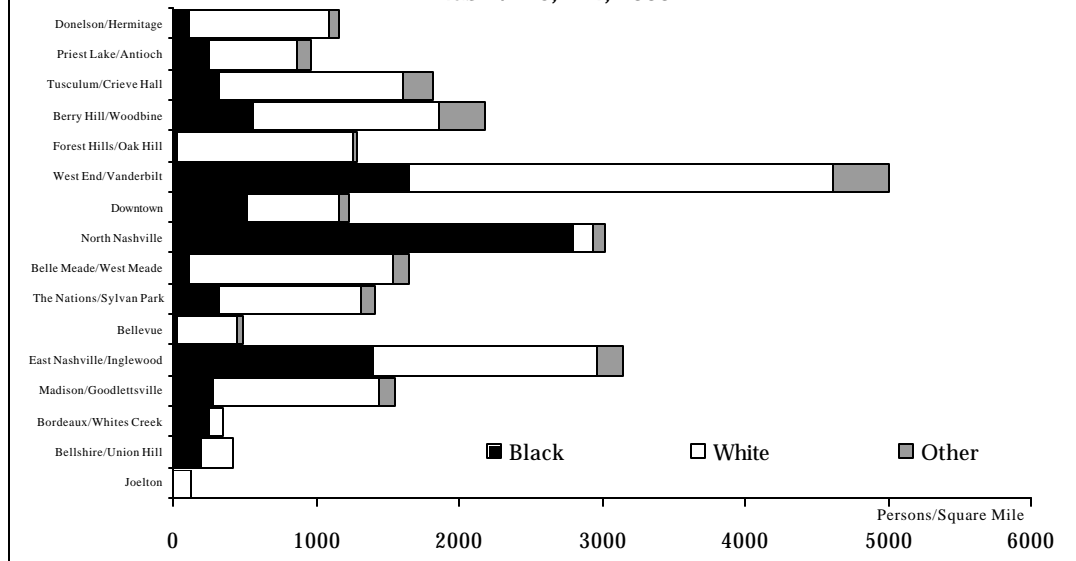


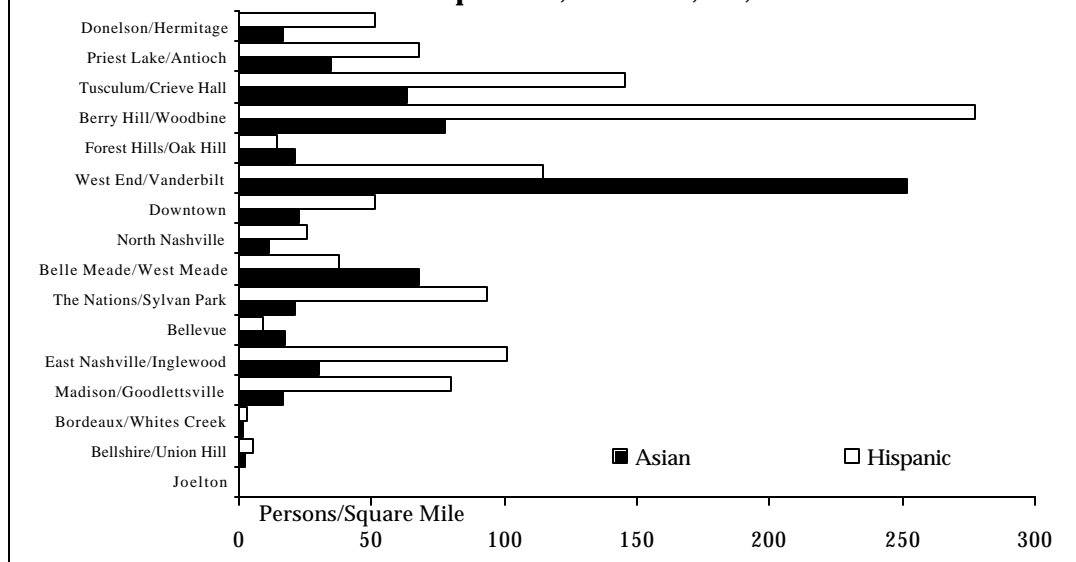
Figure 22 reveals population density by council district for years 1991 - 2002. Council district 18 is the most dense district, while council district 1 is the least dense district. When the council districts were redrawn based on 2000 Census data for years 2003 and forward, the most dense and least dense council districts were still 18 and 1, respectively.

Figure 23. Population Density by Race and Health Planning District, Nashville, TN, 2000



Planning district 6 (West End/Vanderbilt) and council district 18 have the highest population densities (persons per square mile) for whites and other races while planning district 8 (North Nashville) and council district 5 have the highest population densities for blacks.

Figure 24. Population Density by Health Planning District, Hispanic and Asian Population, Nashville, TN, 2000



Figures 23 to 28 display population densities for different racial and gender groups according to 2000 census data estimates. Planning district 10a (West End/Vanderbilt) and council district 18 have the highest population densities (persons per square mile) for whites and other races while planning district 8 (North Nashville) and council district 5 have the highest population densities for blacks. For the Hispanic population, planning district 11 (Berry Hill/Woodbine) and council district 26 have the highest population densities, while the Asian population is most dense in planning district 10a

For the Hispanic population, planning district 11 (Berry Hill/Woodbine) and council district 30 have the highest population densities.

Figure 25. Population Density by Gender and Health Planning District, Nashville, TN, 2000

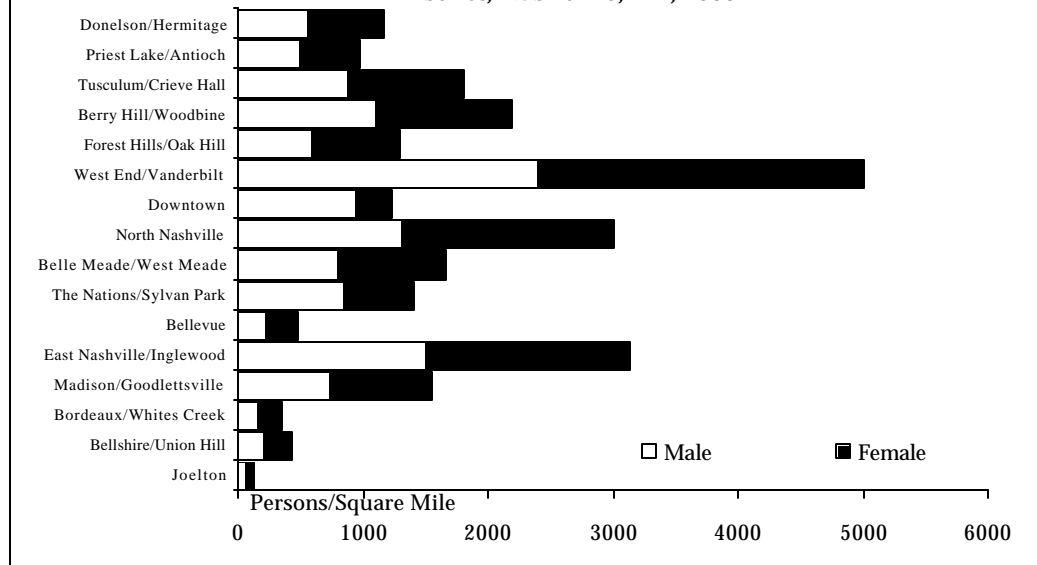
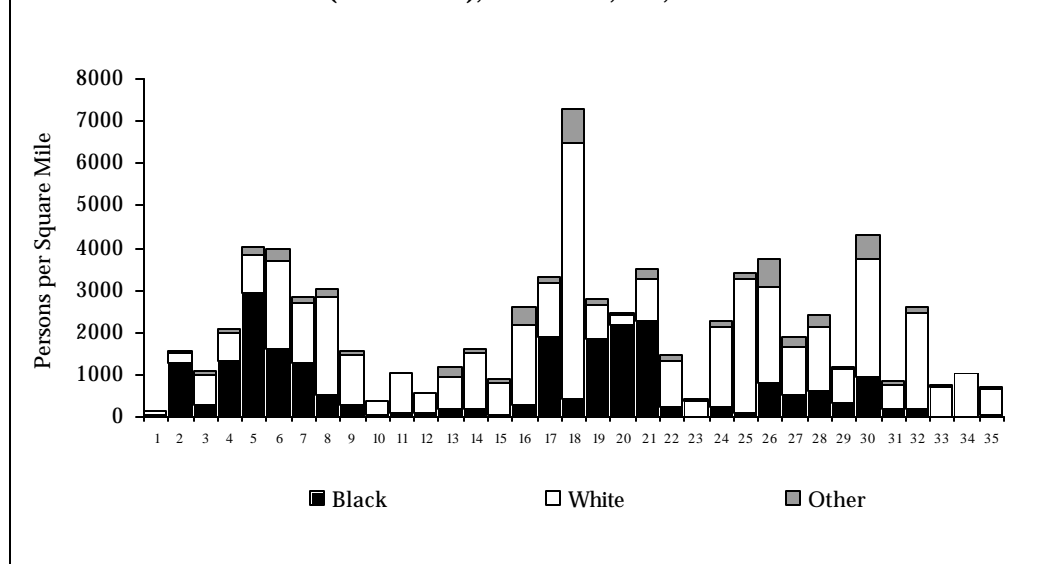
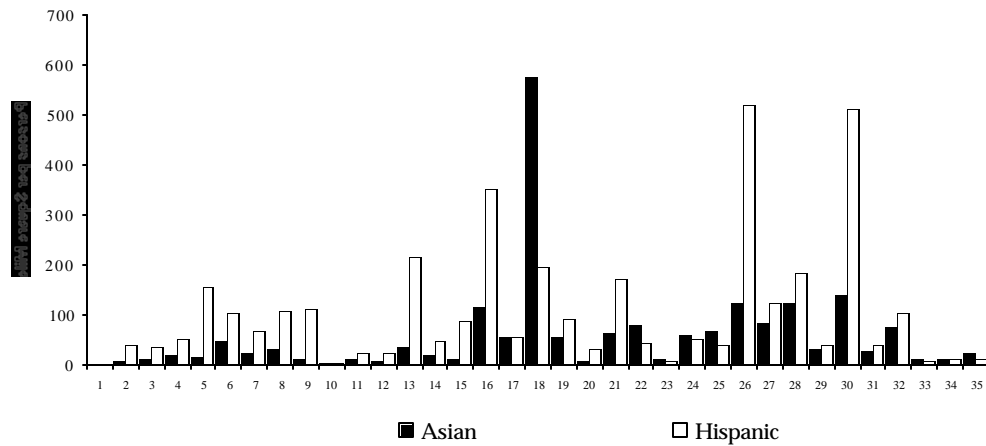


Figure 26. Population Density by Race and Council District, (1991 - 2002), Nashville, TN, 2000



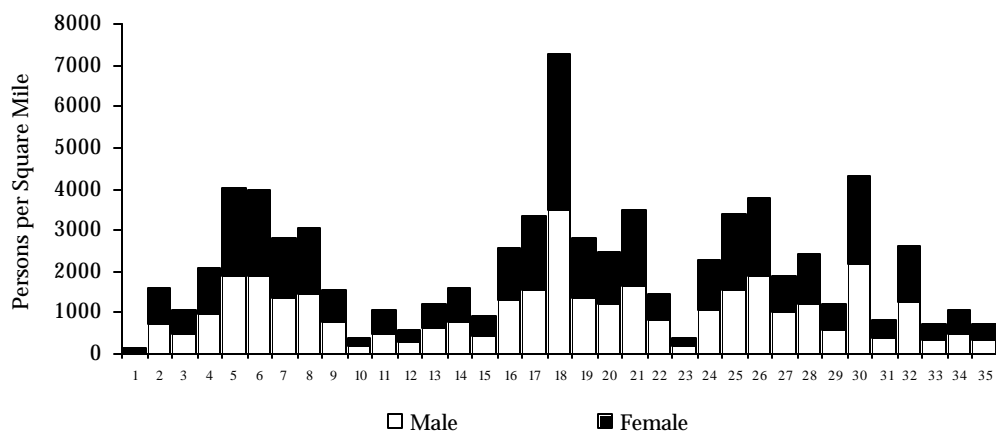
(West End/Vanderbilt) and council district 18. When the council districts were redrawn based on 2000 Census data for year 2003 forward, the most dense council districts for whites and Asians did not change. However, the most dense council district for blacks changed from council district 5 to council district 21; for Hispanics, it changed from council district 26 to council district 30; and for those of other races, it changed from council district 18 to council district 30 (see Data Table 23).

Figure 27. Population Density by Council District (1991-2002), Hispanic and Asian Populations, Nashville, TN, 2000



The Asian population is most dense in planning district 10a (West End/Vanderbilt) and council district 18.

Figure 28. Population Density by Gender and Council District (1991-2002), Nashville, TN, 2000



Discussion

As the largest metropolitan center in Tennessee, Nashville's higher population density is expected. Because of higher population density and diversified distribution of different sub-populations in the area, health service planning and public health interventions need to be designed accordingly.

It is important to note that different racial groups are not equally distributed in Nashville. In other words, some racial groups are concentrated in certain areas. Therefore, to eliminate health disparities in our community, a geographically targeted approach should be considered.

Reference:

1. Fos PJ, Fine DJ. *Designing Health Care for Population*. San Francisco: Jossey-Bass; 2000.

Different racial groups are not equally distributed in Nashville.

Related Indicators

- Poverty level
- Income
- Health care providers

2.1.1.10 Lack of Health Insurance

Background

Lack of health insurance may severely restrict a person's access to timely and quality medical care which can negatively affect a person's health. Failure to get medical treatment for minor conditions can lead to major health complications; for example, untreated bronchitis can lead to pneumonia, a much more serious health problem. Similarly, failure to get preventive medical care such as routine screenings for cervical, breast, or colon cancer may result in a cancer not being identified until a later stage, when treatment options are limited and the chance for survival is much lower.

The U.S. Census Bureau estimates that in 2000 approximately 14% of the U.S. population did not have health insurance coverage.¹ Those most likely to lack health insurance were young adults between the ages of 18 and 24, people with lower levels of education, and people in households with annual incomes of less than \$25,000. The Healthy People 2010 objective is for 100% of the U.S. population to have health insurance by the year 2010.

Additional Data

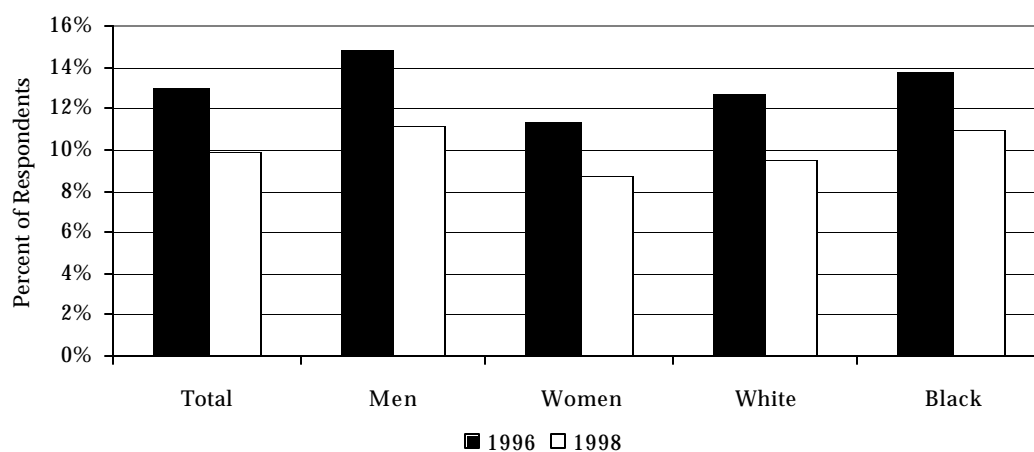
Appendices
pages D-25 - D-26

To estimate health insurance coverage in Nashville, data from the Nashville Behavioral Risk Factor Surveillance Surveys (BRFSS) was used. In both 1996 and 1998, the survey asked respondents "Do you have any kind of health coverage, health insurance....?". The surveys also asked respondents who did not have coverage how long they had been without it. For the purposes of this report, respondents who reported that they did not have insurance or said they didn't know if they had insurance were classified as uninsured.

Findings

Since Medicare is available to nearly all persons age 65 and older, findings in this report concentrate on nonelderly adults – those aged 18 to 64 years. Thirteen percent (13%) of nonelderly adult respondents reported being uninsured in 1996 (Figure 29). Slightly more

Figure 29. Percentage of Respondents Age 18 to 64 Without Health Insurance, Nashville, TN, BRFSS, 1996 and 1998



Data Sources

Metro Public Health
Department: BRFSS

men than women were uninsured (15% compared to 11%). No strong racial disparity was seen. When the respondents were stratified by age, respondents in the 18 to 24 age group had the largest proportion of uninsured (25%) (Figure 30). Fewer respondents were uninsured in the older age groups. Respondents with more education were less likely to be uninsured than those with limited education (Figure 31). Classifying the uninsured respondents by income, the majority were in the lower income brackets. Forty-seven percent (47%) of uninsured respondents said they made less than \$25,000 annually, while 27% earned between \$25,000 and \$49,999 (Figure 32).

Figure 30. Percentage of Respondents Age 18 to 64 Without Health Insurance by Age, Nashville, TN, BRFSS, 1996 and 1998

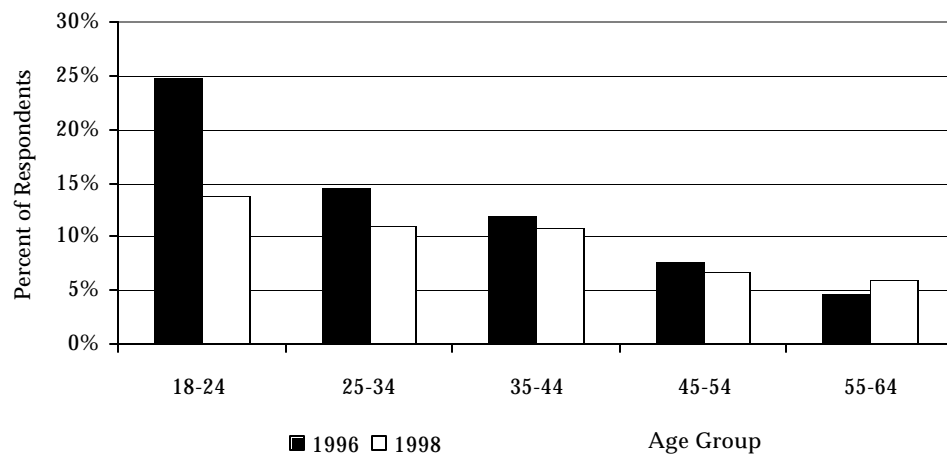


Figure 31. Percentage of Respondents Age 18 to 64 Without Health Insurance by Education, Nashville, TN, BRFSS, 1996 and 1998

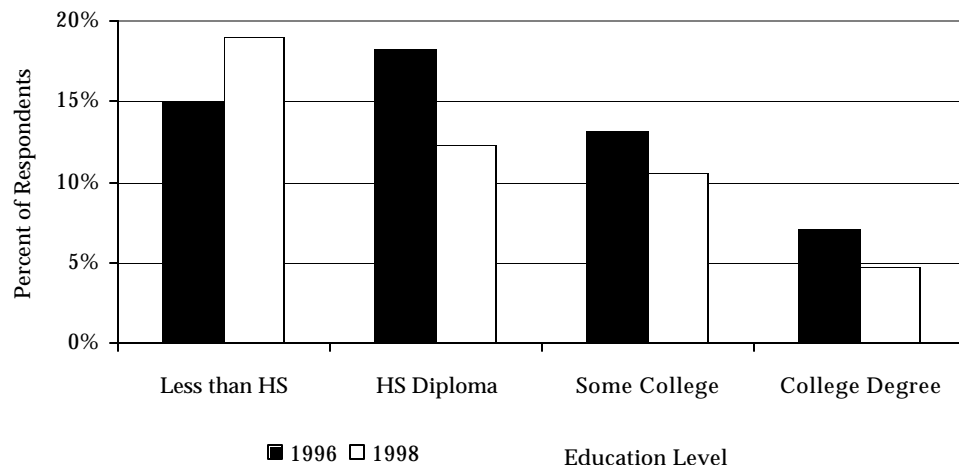
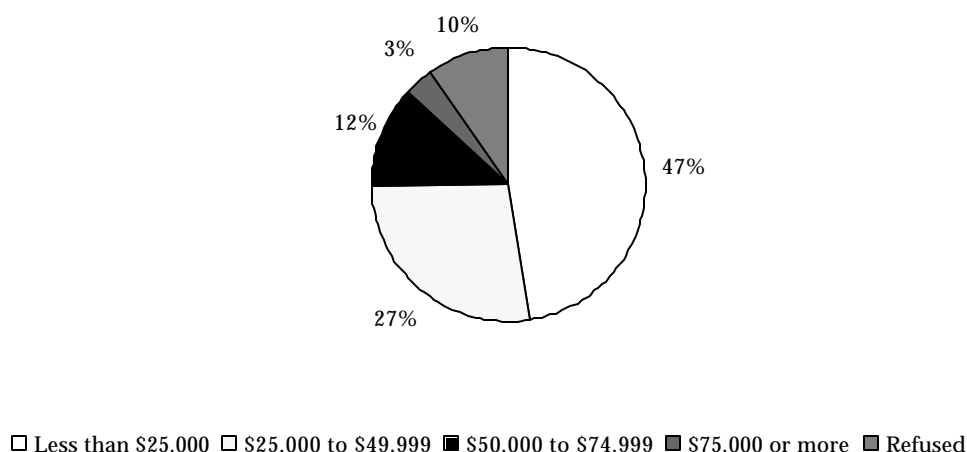


Figure 32. Percentage of Uninsured Respondents Age 18 to 64 by Income, Nashville, TN, BRFSS, 1996



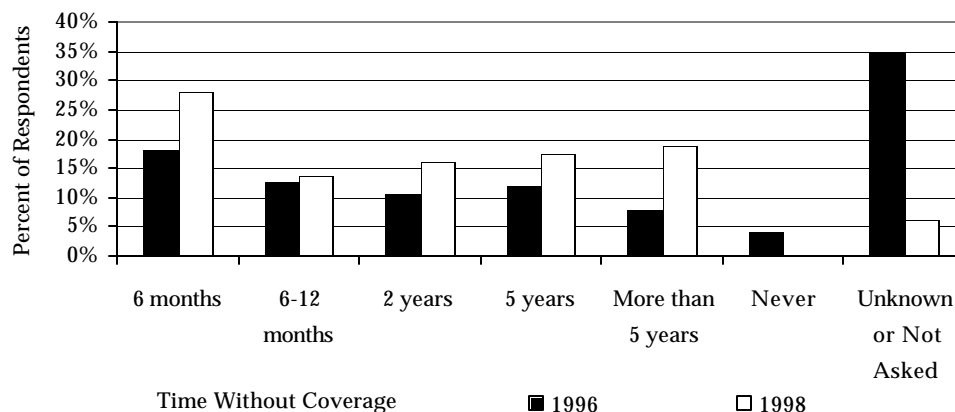
Overall in 2000, Nashville had a smaller proportion of uninsured BRFSS respondents than Tennessee or the U.S.

From 1996 to 1998, there was a drop in the overall proportion of uninsured nonelderly BRFSS respondents— in 1998 only 10% reported being without health insurance. All trends for gender, race, age, income, and time without insurance remained the same; however, the proportion of uninsured respondents who did not complete high school increased from 15% in 1996 to 19% in 1998.

When asked how long they had been without insurance, most nonelderly, uninsured respondents reported being without health insurance for less than 6 months – 18% in 1996 and 28% in 1998 (Figure 33). The difference in percentages from 1996 to 1998 may be an overestimate because fewer respondents were asked how long they had been without insurance in 1996 than in 1998. In 1996, additional questions were asked to probe whether a respondent might have secondary sources of health insurance which were overlooked when answering the initial question. As a result fewer respondents in 1996 were classified as truly being without health insurance. Probing for secondary insurance sources was not done in 1998.

The Tennessee and national BRFSS in 2000 included the same questions used in Nashville to assess health insurance coverage. Overall, Nashville had a smaller proportion of uninsured BRFSS respondents than Tennessee or the U.S. The percentage of uninsured adults (all ages) was age-adjusted to the U.S. 2000 standard population for comparison to the Tennessee and U.S. data. In 1998, the age-adjusted percentage of Nashville BRFSS respondents who did not have health insurance was 8%. Twelve percent (12%, age-adjusted) of Tennessee BRFSS respondents said they were uninsured and the median percentage for the U.S. (median percentage from 50 states, District of Columbia, and Puerto Rico) was also 12%. Nashville's trends for gender, age, and education were similar to those of Tennessee and the U.S. When considering racial disparities, Tennessee and the U.S. both show a bigger gap between white and black respondents than was seen in Nashville. The trend for income was similar, though, Nashville may have a higher proportion of uninsured residents in the \$25,000 to \$49,999 annual income bracket.

Figure 33. Percentage of Respondents Age 18 to 64 Without Insurance by Amount of Time Without Coverage, Nashville, TN, BRFSS, 1996 and 1998



Discussion

The effort to provide uninsured U.S. residents with adequate health care has been underway since the mid 1970s at both state and national levels.² New legislation such as the Health Insurance Portability and Accountability Act and the State Children's Health Insurance Program have made some inroads to offering care to the uninsured. Locally, MPHD, in cooperation with members from public and private medical institutions, hospitals, and clinics, is offering health care to uninsured residents through the Safety Net Consortium and the Bridges to Care Program. The Safety Net Consortium began in May 2000 with the goal of providing an appropriate level of care to uninsured residents. In February 2002, Bridges to Care was initiated to assist uninsured residents in establishing an ongoing primary care relationship with participating Safety Net clinics.

References:

- 1 United States Census Bureau. *Health Insurance Coverage: 2000*. September 2001.
- 2 Riley, T, Yondorf B. *Access for the Uninsured: Lessons from 25 Years of State Initiatives*. Portland, ME: National Academy for State Health Policy; January 2000.

The Safety Net Consortium began in May, 2000 with the goal of providing an appropriate level of care to uninsured residents.

Related Indicators

- Race/ethnic composition of population
- Population density

2.1.1.11 Non-English Speaking Population

Background

The ability to function in an English-language setting is important for an individual's survival, health, and well being in our community. An estimate of the size of the non-English speaking population can be used as an indicator of a community's cultural diversity. Non-English speaking populations may have demographic, social, economic, and health characteristics that differ from the English speaking population.¹ As Nashville's population becomes more diverse, information regarding the proportion of non-English speaking population in our community is very useful in planning, programming, and delivering health services to our culturally diverse population.

Data on the language spoken at home is obtained from the Census 2000 data and will serve as a proxy for the non-English speaking population since it is the data on the language spoken at home. No data is provided on the language spoken at work or school, with friends, etc.; therefore, the data should be used with caution since these data do not tell us the overall language habits of respondents.

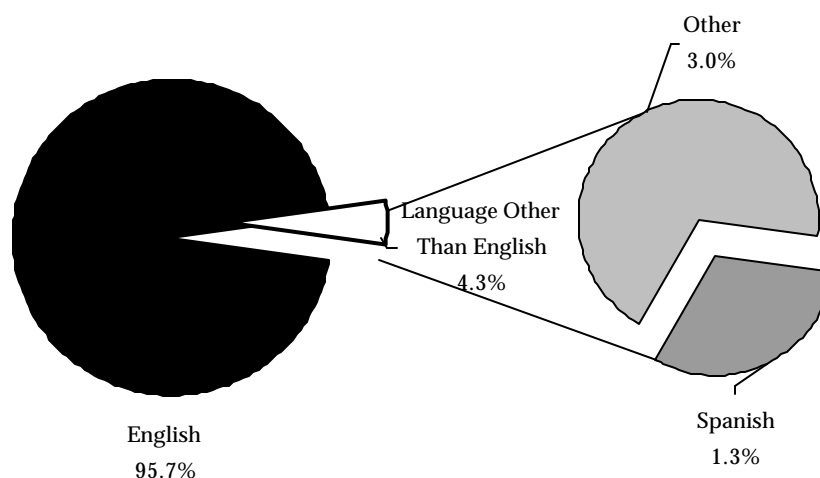
Additional Data

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Findings

From 1990 to 2000, the proportion of the population whose home language was not English increased from 4.3% of the population to 9.8% of the population, while English spoken at home decreased from 95.7% of the population to 90.2 % of the population. As displayed in figures 34 and 35, in 1990, less than one in twenty people spoke a language other than English at home. In 2000, almost one in ten people spoke a language other than English at home. The number of persons who spoke a language other than English at home increased remarkably from 1990 to 2000.

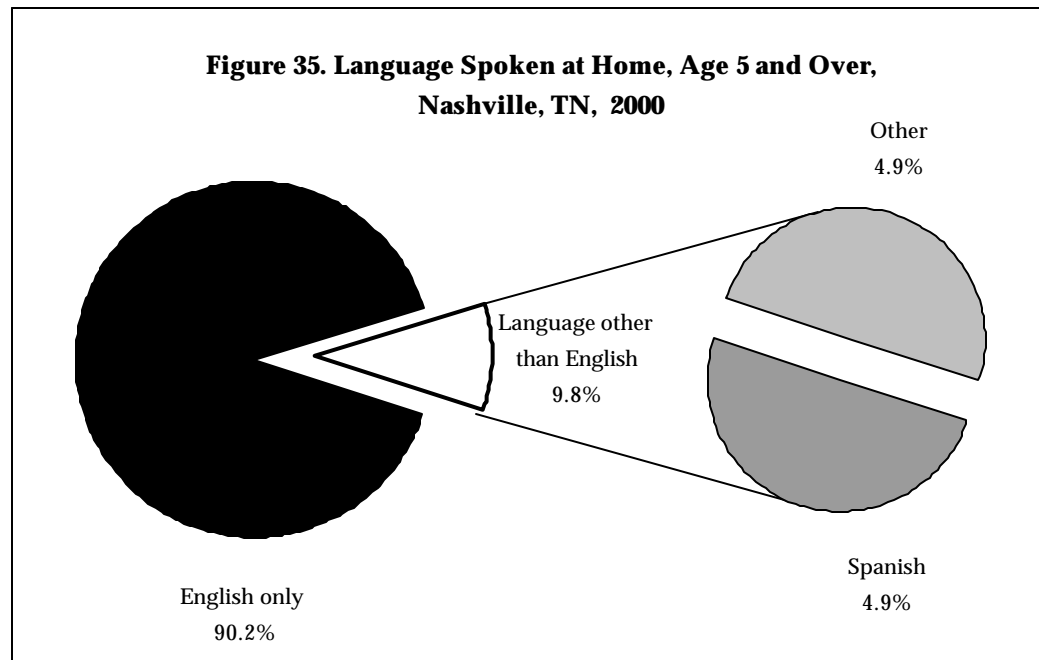
Figure 34. Language Spoken at Home, Age 5 and Over, Nashville, TN, 1990



Data Sources

U.S. Bureau of the Census

For those who spoke non-English at home, the Spanish-speaking population increased the most during the decade, from 1.3% of the Nashville population to 4.9% of the population.



Discussion

The growth of the non-English speaking population in our community highlights Nashville's diversity issue. The community's diversity affects every aspect of public health, from communicable disease control to maternal and child health issues. A culturally competent health care work force is needed in this community.

References :

1. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.

The number of persons who spoke a language other than English at home increased remarkably from 1990 to 2000.

2.1.2 Physical Environment

A physical environment is typically defined as that which is experienced by the senses: sight, touch, taste, smell, and sound. However, the physical environment also contains less tangible elements, such as radiation and ozone. The physical environment can either harm or promote individual and community health. For example, toxic substances, irritants, infectious agents, and physical hazards in homes, schools, and worksites all have a detrimental effect on individual and community health. On the other hand, clean and safe places to work, exercise, and play promote good health in individuals and communities.¹

Reference:

1. U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, in Two Volumes). Washington, D.C.: January 2000.

The physical environment contains tangible elements which can be experienced through the senses of sight, touch, taste, smell, and sound and less tangible elements such as radiation and ozone.

Related Indicators

- Air quality
- Food protection in restaurants and retail food stores
- Public facilities

2.1.2.1 Drinking Water

Background

Clean, potable water is a hallmark to any decent standard of living. Most residents of Nashville use water supplied by the Metropolitan Government of Nashville and Davidson County 's Department of Water Services (Water Services). Other residents of Nashville receive water from a smaller utility that also services areas outside Nashville.

Findings

The source of water utilized by Water Services is the Cumberland River. The majority of Nashville lies in the Lower Cumberland – Sycamore watershed. The U.S. Environmental Protection Agency (EPA) rates the water quality of this watershed as a three on a six point scale. This rating indicates a watershed “where data suggest pollutants or other stresses are low, and, therefore there exists a lower potential for future declines in aquatic health. Actions to prevent declines in aquatic conditions in these watersheds are appropriate but at a lower priority than in watersheds with higher vulnerability.”¹ While it is not possible to completely eliminate all traces of contaminants, the EPA does establish maximum contaminant levels for substances that pose a health risk. In their most recent water quality study in 2001, Water Services reported that Nashville’s drinking water has contaminant levels below the maximum amount permitted by all state and federal standards and is safe to drink.² (Table 1)

According to Water Services, impurities that may be present in our source water include:

- Biological contaminants, such as viruses and bacteria, which may come from sewage treatment plants, septic systems, agricultural livestock operations, and wildlife.
- Inorganic contaminants, such as salts and metals, which can be naturally-occurring or result from urban storm run-off, industrial or domestic wastewater discharges, oil and gas production, mining, or farming.
- Pesticides and herbicides, which may come from a variety of sources such as agriculture, storm water run-off, and residential uses.
- Organic chemicals, including synthetic and volatile organics, which are by-products of industrial processes and petroleum production, and can also come from gas stations, urban storm water run-off, and septic systems.
- Radioactive materials, which can be naturally-occurring or are the result of mining activities or oil and gas production.³

At the Water Service treatment plants water from the river is first screened to remove large objects such as logs. Chemicals, known as coagulants, are added and mixed well. These chemicals do not stay in the water; instead, they cause contaminants such as mud and algae to cling to them forming larger particles. These settle to the bottom of the tanks and are removed mechanically. The water then flows slowly through settling tanks where larger particles are allowed to sink to the bottom. The water from these tanks is passed through filters made of gravel and sand. At this point the water is crystal clear, but before the water enters the distribution system, a small amount of both chlorine and fluoride are added. Chlorine must be added to prevent bacteria from developing. Fluoride is also added because it has been found to prevent tooth decay.⁴

Data Sources

Metropolitan Government
of Nashville and Davidson
County Department of
Water Services
Environmental Protection
Agency

Discussion

Drinking water, including bottled water, may contain at least small amounts of some contaminants. However, the presence of contaminants does not necessarily indicate that water poses a health risk. More information about contaminants and potential health effects can be obtained by calling the Environmental Protection Agency's Safe Drinking Water Hotline 1-800-426-4791.

**Table 1. Water Quality Parameters, Nashville,
TN, 2001**

Selected Parameters	Nashville	MCL
Arsenic	<.004	0.05
Cyanide	<.005	0.2
Lead	0.008	0.015
Nitrate	0.35	10

MCL = Maximum Contaminant Level established

by the Environmental Protection Agency

All results are milligrams per liter

Source: Metropolitan Government of Nashville and
Davidson County, Department of Water Services

References:

1. United States Environmental Protection Agency. Watershed health, lower cumberland-sycamore [online]. Available at: <http://www.epa.gov/iwi/hucs/05130202/score.html>. Accessed May 22, 2002.
2. Metropolitan Government of Nashville and Davidson County Department of Water Services. Water quality report [online]. Available at: <http://www.nashville.gov/water/qualityrpt.htm>. Accessed May 22, 2002.
3. Metropolitan Government of Nashville and Davidson County Department of Water Services. Nashville's water source [online]. Available at: <http://www.nashville.gov/water/source.htm>. Accessed May 22, 2002.
4. Metropolitan Government of Nashville and Davidson County Department of Water Services. The treatment process [online]. Available at: <http://www.nashville.gov/water/treatment.htm>. Accessed May 22, 2002.

Clean, potable water is a hallmark to any decent standard of living.

Related Indicators

Drinking water

2.1.2.2 Air Quality

Background

Exposure to air pollution is associated with numerous effects on human health, including respiratory problems, hospitalization for heart or lung diseases, and even premature death. Children are at greater risk because they are generally more active outdoors and their lungs are still developing. The elderly and people with heart or lung diseases are also more sensitive to some types of air pollution.¹

Air pollution, such as ground-level ozone, can significantly affect ecosystems. Ground level ozone causes reductions of agricultural and commercial forest yields and damages rubber products.¹

Findings

Air pollution comes from many different sources. These include: “stationary sources,” such as factories and power plants; smaller sources such as gas stations and painting operations; “mobile sources,” such as cars, buses, planes, trucks, and trains; and “natural sources,” such as windblown dust, wildfires and certain trees (Table 2).

Table 2. 2000 Nashville Annual Emission Inventory²

	Particulate*	Sulfur Oxides*	Nitrogen Oxides*	Carbon Monoxide*	Volatile Organic Compounds (VOC)*
Stationary Sources					
Transportation & Marketing of VOC	0.0	0.0	5.1	18.8	675.9
Industrial Processes	496.2	355.8	1672.0	3896.1	1675.2
Non-Industrial Surface Coating	0.0	0.0	0.0	0.0	1999.1
Other Solvent Use	0.0	0.0	0.0	0.0	3003.7
Miscellaneous Sources	21191.1	0.7	1.7	30.8	510.7
Fuel Combustion	477.0	8206.2	3063.4	2212.5	1249.9
Solid Waste Disposal	64.5	95.8	459.5	548.6	101.1
Total Stationary Sources	22228.7	8658.5	5201.6	6706.8	9215.6
Mobile Sources					
On-Road Mobile	1183.8	2583.2	18548.3	81265.0	8556.5
Non-Road Mobile	48.1	58.5	4824.9	34597.8	4475.1
Total Mobile Sources	1231.9	2641.7	23373.2	115862.8	13031.5
Total All Sources	23460.7	11300.2	28574.9	122569.5	22247.2

Data Sources

Metro Public Health
Department
Environmental Protec-
tion Agency
Tennessee Department
of Health

*All measurements are reported in tons per year.

The data presented in Table 2 is the calculated sum of the air pollution emissions in Davidson County, Tennessee for 2000. These values are neither high nor low, but represent the Pollution Control Division's best estimate of air emissions. Generally, the lower these values are, the lower the values are from our air quality measurement sites.

The Clean Air Act provides the principal framework for national, state, tribal, and local efforts to protect air quality. The Metropolitan Public Health Department's Pollution Control Division is responsible for carrying out these responsibilities in Davidson County. These responsibilities include monitoring for the six criteria pollutants for which National Ambient Air Quality Standards (NAAQS) have been set under the Clean Air Act and enforcing all air quality regulations.

Products of the Pollution Control Division include:

- Review of permit applications for potential air pollution sources;
- Preparation of an annual air pollution emissions inventory;
- Response to complaints from the public regarding both indoor and outdoor air quality;
- Provision of a daily report of Nashville's air quality to the public in the form of the Air Quality Index (AQI); and
- Participation with the Tennessee Air Pollution Control Division in providing a Middle Tennessee ozone forecast from May through September. (Tables 3 & 4)

Table 3. 2001 Air Quality Index Summary for Nashville, TN*³

Range	Number of Days	% of Total Days
Good	134	53%
Moderate	114	46%
Unhealthy for Sensitive Groups	3	1%

*Includes Davidson County only.

Table 4. 2001 Ozone Forecasting for Middle Tennessee³**

Category	# Days Forecast	# Days Observed
Good	77	91
Moderate	64	54
Unhealthy for Sensitive Groups	8	8
Unhealthy	0	0
Very Unhealthy	0	0

**Includes the Middle Tennessee counties of Cheatham, Davidson, Dickson, Robertson, Rutherford, Sumner, Williamson, and Wilson

Discussion

Currently, Nashville/Davidson County is in compliance with all National Ambient Air Quality Standards. Most likely, that will change in the near future. The Environmental Protection Agency (EPA) has proposed new, stricter standards for ozone and fine particulate matter.⁴ Instead of the current 1-hour average ozone standard of 0.12 ppm (parts per million), the ozone standard will become a stricter standard of 0.08 ppm averaged over eight hours. The fine particulate matter (PM_{2.5}) is a new standard. The new (PM_{2.5}) standard will be 65 micrograms per cubic meter averaged over 24 hours and 15 micrograms per cubic meter averaged over an entire year. Initial data indicates Nashville will not be in compliance with the stricter 8-hour ozone standard or the new annual average (PM_{2.5}) standard.

However, there are federal, state, and local initiatives underway that will reduce ozone precursors and particulate matter. There are programs at the federal level that require cleaner gasoline and diesel engines and the reduction of sulfur content in gasoline and diesel fuel. The NOx SIP (Nitrogen oxides/State Implementation Plan) call requires large fuel burning sources to better control emissions. There are local and state programs for enhanced automobile inspection and maintenance programs. There are ozone forecasting programs in place that advise residents when a high ozone day is expected so that plans can be adjusted to minimize health impacts and keep ozone levels at a minimum. All of the Tennessee local air programs, as well as the states of Arkansas, Tennessee, and Mississippi air programs, are involved in the Arkansas Tennessee Mississippi Ozone Study (ATMOS). ATMOS activities will result in a comprehensive evaluation of the status of the participating areas in relation to the 8-hour ozone standard. If compliance is not achieved by means of the current and proposed initiatives, ATMOS results will provide air pollution control strategies to bring Nashville and the participating areas into compliance with the 8-hour ozone standard.

References:

1. United States Environmental Protection Agency. Available at: <http://www.epa.gov/air/concerns>. Accessed June 6, 2002.
2. Metropolitan Health Department of Nashville and Davidson County, Tennessee. *2000 Annual Report*.
3. Metropolitan Nashville and Davidson County and Tennessee Department of Health Pollution Control Division. *Air Quality Index and Ozone Forecast Data, 2001*.
4. United States Environmental Protection Agency. Available at: <http://www.epa.gov/ttn/oarpg/naaqsfm/>. Accessed June 6, 2002.

Currently, Nashville and Davidson County is in compliance with all National Ambient Air Quality Standards.

Related Indicators

- Drinking water
- Solid and hazardous waste

2.1.2.3 Sewage

Background

For the safe and effective management of wastewater, our building codes mandate that all structures with plumbing facilities must be connected to a public sewer system or utilize an approved private on-site subsurface sewage disposal (septic) system.

Findings

According to the 1990 U.S. Census, of the 229,064 households in Nashville approximately 92% were connected to one of the public sewer utilities with service areas within Nashville. The remaining 8%, approximately 18,000 households, utilized a septic system. According to the records of MPHD's Division of Engineering Services, in fiscal year 2001, the Division inspected 135 new septic systems.

Discussion

Although the percentage of septic systems may seem marginal, they remain an active concern of MPHD. Much of the current development is occurring in outlying areas of the county where public sewer service is not available. Furthermore, the terrain and geology of the area make the proper installation of a septic system both difficult and critical. Contaminants introduced into our groundwater supply can spread quickly and reach underground aquifers and springs presenting health hazards to both public and private water supplies.

Most homes and businesses in Nashville that utilize public sewer connections are serviced by Metro's Department of Water Services. Water Services maintains three wastewater treatment plants that, in accordance with state and federal regulations, implement a series of sanitation techniques including filtering, settling, aeration, and chlorination. Treated wastewater from the three facilities is discharged into the Cumberland River.¹

Reference:

1. Metropolitan Government of Nashville and Davidson County Department of Water Services. Waste water treatment process [online]. Available at: <http://www.nashville.gov/water/h2otreatment.htm>. Accessed May 22, 2002.

Data Sources

Metropolitan
Government of Nashville
and Davidson County
Department of Water
Services

According to the 1990 U.S. Census, of the 229,064 households in Nashville approximately 92% were connected to one of the public sewer utilities with service areas within Nashville. The remaining 8%, approximately 18,000 households, utilized a septic system.

Related Indicators

Sewage

2.1.2.4 Solid & Hazardous Waste**Background**

Effective waste management is critical in our efforts to protect the environment and maintain a decent quality of life. The Public Works Department of the Metropolitan Government of Nashville and Davidson County (Public Works) oversees solid waste collection and maintains a household hazardous waste drop-off site. The Comprehensive Environmental Response Compensation and Liability Act (CERCLA) passed by the U.S. Congress in 1980 provides the U.S. Environmental Protection Agency (EPA) with the means to prioritize and clean up hazardous waste sites. The EPA maintains a National Priorities List (NPL) of the most hazardous sites. As of July 2002, there are no NPL sites in Nashville.¹

Findings

Most residents of Nashville live in the area designated as the Urban Services District for which weekly trash collection is provided at no charge. Other residents, living in the General Services District, must make arrangements with private firms for trash collection.

A new waste management plan has recently been approved by the Metropolitan Council. Previously, all solid waste was either transported to an out-of-county landfill or converted into energy at the Metropolitan Government's Thermal Transfer Plant. Under the new plan all solid waste will be transported to landfills outside of Nashville, and the Thermal Transfer Plant was scheduled for retirement. Due to an accidental fire in the spring of 2002, the Thermal Transfer Plant was shut down ahead of schedule.

Discussion

Public Works also manages a hazardous waste collection center where citizens are encouraged to dispose of items such as paint, pesticides, batteries, and cleaning agents. For residents of the Urban Services District, monthly curbside recycling is being implemented as part of the new waste management plan. Citizens are encouraged to deposit recyclable waste that is not collected as part of the curbside recycling plan at one of many collection centers managed by Public Works. Please contact Public Works for the locations and hours of operation for these sites. Public Works can be reached at 615-880-1000 or on the internet at <http://www.nashville.gov/pw/index.htm>.

Reference:

1. United States Environmental Protection Agency: Superfund. Available at: <http://www.epa.gov/superfund>. Accessed July 16, 2002.

Data Sources

Metropolitan Government
of Nashville and Davidson
County Public Works
Department
Environmental Protection
Agency

Effective waste management is critical in our efforts to protect the environment and maintain a decent quality of life.

Most residents of Nashville live in the area designated as the Urban Services District for which weekly trash collection is provided at no charge.

Related Indicators

Health status and quality of life

2.1.2.5 Lead Poisoning

Background

Lead poisoning is an environmental health hazard for which young children are especially susceptible. A leading source of exposure to lead is through lead-based house paint. Prior to its banning in 1978, lead-based paint was widely used in residential construction and renovation. More than 80 percent of homes built before 1980 contain lead paint.¹ Residents of these older homes are threatened by chipping or peeling lead paint, or excessive amounts of lead-contaminated dust. Children are especially at risk because they are more likely to eat lead-based paint chips and place objects covered with lead dust in their mouths. Other sources of lead include contaminated soil, water from older, lead pipe plumbing systems, folk remedies containing lead, and hobbies and industries that utilize lead.

Even at low levels, lead poisoning in children can cause IQ deficiencies, reading and learning disabilities, impaired hearing, reduced attention spans, hyperactivity, and other behavior problems. Pregnant women poisoned by lead can transfer lead to a developing fetus, resulting in adverse developmental effects.² The younger the child is at the time of exposure the greater the harmful effects of lead poisoning. While the damage resulting from lead poisoning cannot be undone it can be prevented. A blood test is the only way to know if a child is being exposed. This test can be done as early as six months of age.

Findings

The MPH's Division of Environmental Sanitation conducts environmental assessments that test for lead. These assessments are generally conducted if a physician or clinic detects a high lead level in a patient's blood. According to records of the Division of Environmental Sanitation for fiscal year 2000, 15 such assessments were conducted by the Division.

Discussion

Despite being banned in 1978, lead-based paint remains a significant concern. Many neighborhoods in Nashville consist of homes that were built when lead-based paint use was common. Precautions should be taken when living in or renovating a home that may have lead-based paint. For additional information pertaining to environmental assessments for lead and renovating homes that contain lead-based paint contact the Division of Environmental Sanitation at 615-340-5644.

References:

1. United States Environmental Protection Agency. Prevention, pesticides, and toxic substances: lead in your home: a parent's reference guide [online]. EPA 747-B-98-002. June 1998. Available at: <http://www.epa.gov/lead/leadpbed.htm>. Accessed May 23, 2002.
2. United States Environmental Protection Agency. Lead and compounds [online]. Available at: <http://www.epa.gov/ttn/atw/hlthef/lead.html>. Accessed May 23, 2002.

Data Sources

Metro Public Health
Department
Environmental Protection
Agency

Even at low levels, lead poisoning in children can cause IQ deficiencies, reading and learning disabilities, impaired hearing, reduced attention spans, hyperactivity, and other behavior problems.

Related Indicators

Notifiable diseases
affecting the
gastrointestinal tract

2.1.2.6 Food Protection in Restaurants and Retail Food Stores

Background

Foodborne illness presents a significant threat to the health of the public. While the specific causes of foodborne illness vary, they generally result from improper food handling and meal preparation techniques. Without proper food protection procedures the chances for the introduction of disease-causing bacteria and viruses into the food supply increases considerably. Examples of foodborne pathogens include *campylobacter jejuni*, *clostridium botulinum*, *Escherichia coli* 0157:H7 (E. coli), Norwalk-like virus, and hepatitis A. Symptoms range from mild to severe and can include nausea, vomiting, diarrhea, and fever as well as difficulties with vision, breathing, and speaking. These symptoms may appear less than an hour after ingestion of the pathogen or after several days. In extreme cases, a foodborne illness may result in death.¹

MPHD's Food Protection Division provides protection from the threat of foodborne illness by conducting inspections among Nashville's food service establishments (restaurants, snack bars, and school cafeterias) and retail food stores (groceries or markets).

Findings

According to the Food Protection Division's records for fiscal year 2001, 12,500 inspections were conducted. Currently, there are approximately 2,750 food service establishments and 750 retail food stores with food permits within Nashville. The Division conducts unannounced food inspections at least twice each year among these food establishments. The Division uses a FDA-approved, standardized 44-point food service establishment inspection process. MPHD also provides basic food protection training; a training program targeted at high school students due to their likelihood to seek employment in a restaurant; a program targeted to churches, clubs, and civic groups; and a program that fosters self-inspection procedures for restaurant managers. (See Section 3.4.1.1 for additional information pertaining to diseases that may be foodborne.)

Discussion

Because the quality of the food we eat has a direct impact on our health, the Food Protection Division is constantly working with the markets and restaurants of Nashville to ensure the proper food preparation and storage. Citizens with concerns regarding food preparation techniques or with a particular restaurant or market should not hesitate to contact the MPHD's Food Protection Division at 615-340-5620.

Reference:

1. U.S. Food and Drug Administration. The unwelcome dinner guest: preventing foodborne illnesses [online]. Available at: <http://www.cfsan.fda.gov/~dms/fdunwelc.html>. Accessed May 23, 2002.

Data Sources

Metro Public Health
Department
U.S. Food and Drug
Administration

The quality of the food we eat has a direct impact on our health.

Related Indicators

Drinking water

2.1.2.7 Public Facilities

Background

Nashville’s residents and visitors expect clean and safe facilities and accommodations. MPHD’s Division of Public Facilities conducts environmental health and safety inspections of public swimming pools, hotels and motels, day care centers, schools, correctional facilities, and tattoo parlors located in Nashville. The program responds to complaints pertaining to these establishments to ensure the continued health and safety of the public.

Findings

According to the Public Facilities Division’s records for fiscal year 2000, the Public Facilities Division made 5,188 swimming pool inspections with 158 of those resulting in a pool closing until the violation could be corrected. In that same time period there were 638 hotel inspections and 731 child care facility inspections.

Discussion

The selection of a day care facility or a hotel should be based in part on its sanitary condition. The MPHD’s Public Facilities Division maintains inspection records on these facilities and others throughout Nashville. The Public Facilities Division may be reached at 615-340-5630.

Data Sources

Metro Public Health
Department

For fiscal year 2000, the Public Facilities Division made 5,188 swimming pool inspections with 158 of those resulting in a pool closing until the violation could be corrected. In that same time period there were 638 hotel inspections and 731 child care facility inspections.

2.2 Lifestyle and Behavioral Risk Factors

Diseases, conditions, and injuries responsible for most of the premature death and disability in the United States could be substantially reduced through lifestyle and behavioral modifications.¹ In response to the emerging evidence for the association between lifestyle and behavior and risk for disease and injury, the CDC established the Behavioral Risk Factor Surveillance System (BRFSS) in 1984.² The BRFSS is designed to estimate the prevalence of many health risk behaviors at the state and national level. MPHD conducts a similar BRFSS to assess the health risk factors that exist in Nashville. In the following section, we will examine behavioral risk factors that predispose Nashville residents to many of the leading causes of death – heart disease, stroke, cancer, and accidents. These four causes of death accounted for 63% of the deaths in Nashville in 2000, and robbed 28,000 years of life from our residents as a result of premature death.

References:

1. Bauer KC. *Improving the Chances for Health: Lifestyle Change and Health Evaluation*. San Francisco, CA: National Center for Health Education; 1980.
2. Centers for Disease Control and Prevention. Description of the behavioral risk factor surveillance system. Available at: <http://www.cdc.gov/brfss/about.htm>. Accessed June 3, 2002.

Behavioral risk factors predispose Nashville residents to many of the leading causes of death including heart disease, stroke, cancer, and accidents, which accounted for 63% of the deaths in Nashville in 2000 and robbed 28,000 years of life from our residents as a result of premature death.

2.2.1 Physical Activity

Related Indicators

- Overweight and obesity
- Unhealthy days
- Activity limitation days
- Leading causes of death

Background

The 1996 report of the U.S. Surgeon General on physical activity and health summarizes scientific research supporting the basic fact that regular physical activity can improve and maintain general health and quality of life for persons of all ages. The list of specific medical conditions which might be attenuated by increased levels of physical activity includes certain cancers, osteoporosis, arthritis, heart disease, diabetes, hypertension, and disability. Increased physical activity is also associated with longer life.¹

In 1995, a joint recommendation was made by the Centers for Disease Control and Prevention (CDC) and the American College of Sports Medicine for each person to engage in moderate physical activity on all or most days of the week, for at least 30 minutes a session.² Moderate activity is considered to be any activity that uses large muscle groups and is at least equivalent to brisk walking.³ The Healthy People 2010 objective most closely related to this recommendation is Objective 22-2. – “increase the proportion of adults who engage regularly/daily in moderate physical activity for at least 30 minutes per day to 30%”.³ Without a measure of exertion and without knowing the type of activity (walking, swimming, etc.), we cannot determine if respondents to the Nashville BRFSS did *moderate* physical activity, but we can estimate how many were active, in some manner, for the recommended duration and frequency.

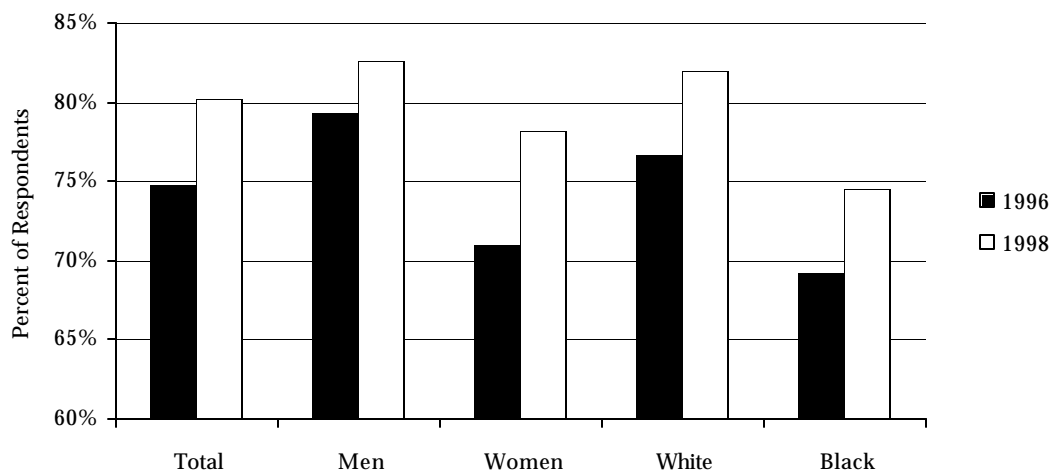
Additional Data

Appendices
pages D-30 - D-31

Findings

Overall, a large percentage of respondents to the BRFSS said they are physically active – 75% in 1996 and 80% in 1998 (Figure 36). In both years, more men than women and more whites than blacks reported being active. Physical activity was more commonly reported in persons in the younger age groups (Figure 37). A smaller proportion of respondents with a high school diploma or less education reported being physically active than college

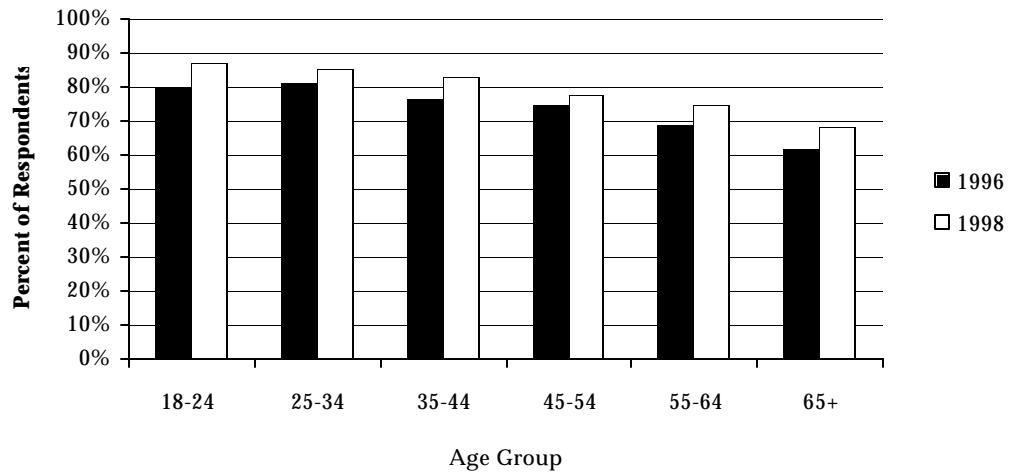
Figure 36. Respondents Who Were Physically Active in the Prior Month, BRFSS, Nashville, TN, 1996 and 1998



Data Sources

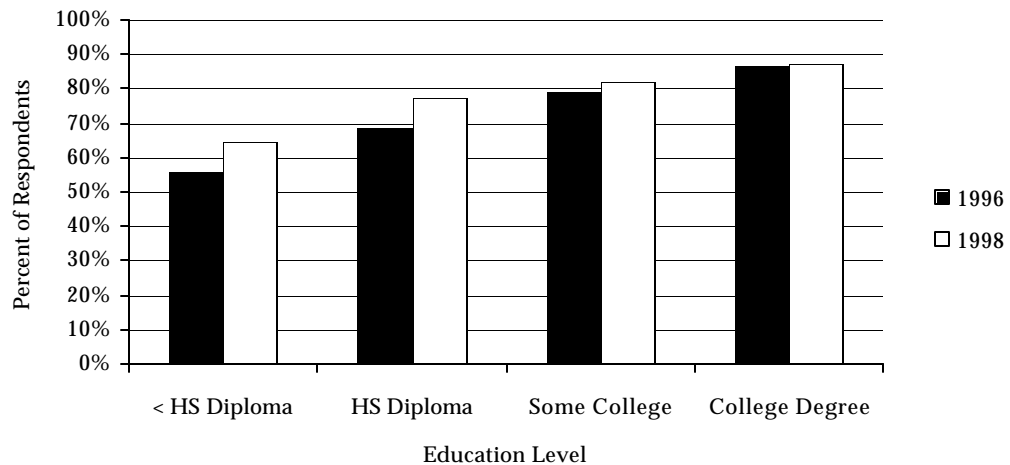
Metro Public Health
Department: BRFSS

Figure 37. Respondents Who Were Physically Active in the Prior Month by Age Group, BRFSS, Nashville, TN, 1996 and 1998



Overall, a large percentage of respondents to the BRFSS said they are physically active.

Figure 38. Respondents Who Were Physically Active in the Prior Month by Education Level, BRFSS, Nashville, TN, 1996 and 1998



graduates (Figure 38). The general trend from 1996 to 1998 was a small increase in reported physical activity for all gender, race, age, and education-level groups.

When we consider frequency and duration of each physical activity session, less than one quarter of respondents were physically active at the level recommended by the Surgeon General's report. In 1996, 24% of respondents were active for at least 30 minutes on five days per week. In 1998, 17% of respondents reported their five times per week activity lasted at least 30 minutes each time. Considering a less stringent schedule of being active three times per week or more, in 1996, 58% of respondents

Compared to both Tennessee and the nation, Nashville appears to have more physically active people.

maintained the activity for 30 minutes or more, three times a week. In 1998, 34% of the respondents who said they were physically active in the last month did activity at least three times a week and for at least 30 minutes at each activity session.

Compared to both Tennessee and the nation, Nashville appears to have more physically active people (Table 5). In 1998, the percent of physically active persons was 16 points higher in Nashville than in the state and 8 points higher than in the U.S. Even when duration and frequency of activity are considered, Nashville residents are still doing slightly better than the U.S., but have not reached the Healthy People 2010 target. The age-adjusted proportion of Nashville BRFSS respondents who were active for 30 minutes, 5 times a week, was 25% in 1996 and 17% in 1998. From National Health Interview Survey data used to calculate the baseline estimates for Healthy People 2010 objectives, the estimated proportion of U.S. adults who also met this criteria was only 15% in 1997.

Table 5. Age-adjusted* Rates of BRFSS Respondents Who Reported Being Physically Active in the Month Prior to Survey, Nashville 1996 and 1998, TN 1998, and U.S. 1998

	Nashville, TN 1996	Nashville, TN 1998	Tennessee 1998	U.S. 1998
Total	74%	80%	64%	72%
Men	79%	82%	67%	74%
Women	71%	78%	62%	70%
White	76%	82%	65%	74%
Black	68%	72%	61%	66%

* Adjusted to the U.S. 2000 standard population.

Discussion

While all people in Nashville would benefit from being physically active, the results presented here suggest that women, blacks, and persons in older age groups are most in need of physical activity promotion initiatives. We must note that the estimates of physical activity in this chapter are very likely overestimates because they are based on self-reported data. Furthermore, the trends we noticed may also be biased by differences in the BRFSS questionnaires from 1996 to 1998. For instance, the reduction in the percentages from 1996 to 1998 may be due to the lack of detail in the 1998 survey questions. In 1996, the respondents were first asked about the specific activity in which they engaged (e.g. walking, swimming, gardening, etc.) and then asked about frequency and duration of that activity. In 1998, they were not asked what type of activity they did. Without asking for the type of activity, the respondent may be biased in their reporting of frequency and duration because a frame of reference is not set, as would be if they reported that they jogged or swam three times a week.

There are two community-based programs associated with MPHD that promote better health through physical activity – REACH 2010 and Walk Nashville. REACH 2010 is a CDC funded program. Its main focus is to reduce cardiovascular disease and diabetes in the North Nashville community, a community which is predominantly black and has high rates of these and related conditions. REACH 2010's strategic plan includes physical activity as one modifiable risk factor and has organized a team to address this issue. The team works to create readiness to change in the community, develop a behavioral support

system, and remove environmental barriers to walking and exercise. Walk Nashville is a city-wide joint project of the Community Health and Wellness Team facilitated by MPH. It targets residents of all ages through various physical activity promoting events. Walk Nashville also seeks to identify and remove environmental barriers to walking such as sidewalks.

References:

1. U.S. Department of Health and Human Services. *Physical Activity and Health. A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion; 1996.
2. Pate RR, Pratt M, Blair SN, Haskell WL, Macera CA, Bouchard, C, et al. Physical activity and public health: a recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. *Journal of the American Medical Association*. 1995;273:402-407.
3. U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, in Two Volumes). Washington, D.C.: January 2000.

While all people in Nashville would benefit from being physically active, the results presented here suggest that women, blacks, and persons in older age groups are most in need of physical activity promotion initiatives.

Related Indicators

- Physical activity
- Unhealthy days
- Leading causes of death
- Cancer incidence

2.2.2 Overweight and Obesity

Background

The prevalence of overweight and obesity is steadily increasing in Tennessee and the United States. In 1999, approximately 52.5% of Tennesseans were overweight or obese according to a 3-year average of Tennessee BRFSS data. This was a 2.1 point increase from the 1998 estimate of 50.4%.¹ The most recent estimate of the overweight population in the United States was 61% in the 1999 National Health and Nutrition Examination Survey (NHANES), a 5 point increase from 56 in 1994.² The growing rate of obesity is reflected in many of the health problems faced by Nashville's residents. Obesity is a major risk factor for heart disease, non-insulin dependent diabetes, and some cancers. A recent national study on obesity estimated that 69% of diabetes and 40% of heart disease are attributable to obesity³, consuming 5% of the total health care costs in the United States, or \$53 billion (1995 dollars). Heart disease is the most common cause of death in Nashville (see Section 3.3). Cancer ranks 2nd and diabetes 8th. Nashville must closely monitor the rate of obesity in its residents not only to guide prevention, but prepare for resident's health needs.

Additional Data

Appendices
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The criteria for defining overweight and obesity are based on the National Institutes of Health and World Health Organization classifications of body mass index. The body mass index (BMI) is calculated from body weight and height ($\text{BMI} = \text{weight in kilograms}/(\text{height in meters})^2$). Overweight is classified as BMI greater than 24.9 kg/m^2 and obesity is classified as BMI greater than 29.9 kg/m^2 .⁴ The Healthy People 2010 goal (Objective 19.1) for increasing the proportion of adults who are at a healthy weight ($\text{BMI} \geq 18.5$ and < 25) sets the goal at 60% of adults aged 20 years and older in the United States, or, rather, only 40% of adults should be overweight by 2010. Objective 19.2 targets the obese proportion of the population, with the goal to reduce this percentage to just 15% of the adult (over age 20) population.⁵ The best measure of determining overweight is actual measurement of body weight and height. In Nashville, we do not have a public source of information containing such actual measures. However, from the Behavioral Risk Factor Surveillance Survey (BRFSS) we can estimate the prevalence of overweight and obesity.

Findings

Figure 39 shows the percentage of Nashville adult residents (age 18 and older) who were classified as overweight, according to data collected by telephone surveys conducted for the BRFSS in 1996 and 1998. In the total population, 49% of adult residents were estimated to be overweight or obese in 1996 and 53% in 1998. More men than women were estimated to be overweight, as were more black residents than white. When the population is stratified into age groups (Figure 40), we see that the prevalence of overweight is greater in the older age groups – in 1998, only 39% of the 18-24 age group were overweight, while 63% of the 55-64 age group were. And when splitting the population by level of education (Figure 41), a smaller proportion of residents with a college education was overweight compared to those with less than a high school diploma. The general trend from 1996 to 1998 was an overall increase in overweight and obesity in Nashville.

Data Sources

Metro Public Health
Department: BRFSS

A similar proportion of the Nashville population is overweight compared to the Tennessee and U.S populations (Table 6). Nashville followed the same trend as the state in that more blacks were overweight than whites and more men were estimated to be overweight than women.

Figure 39. Overweight per Body Mass Index, BRFSS, Nashville, TN, 1996 and 1998

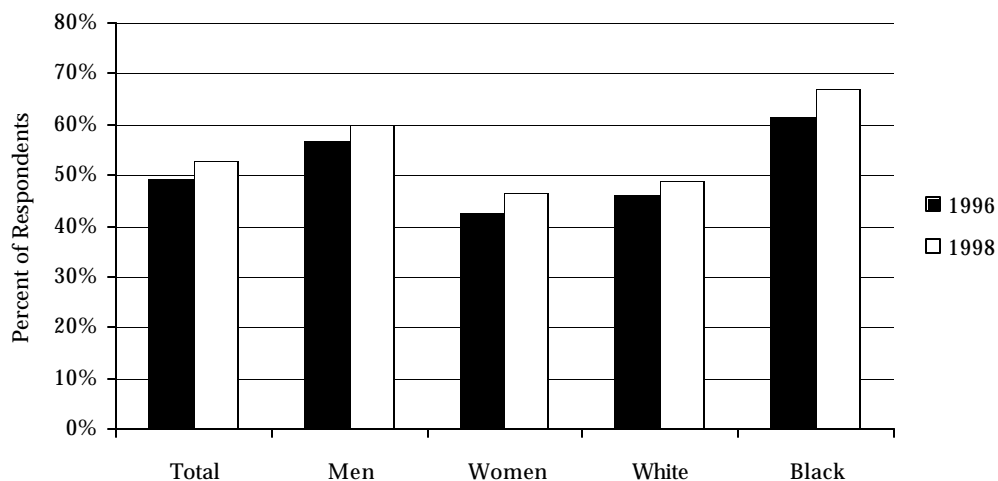
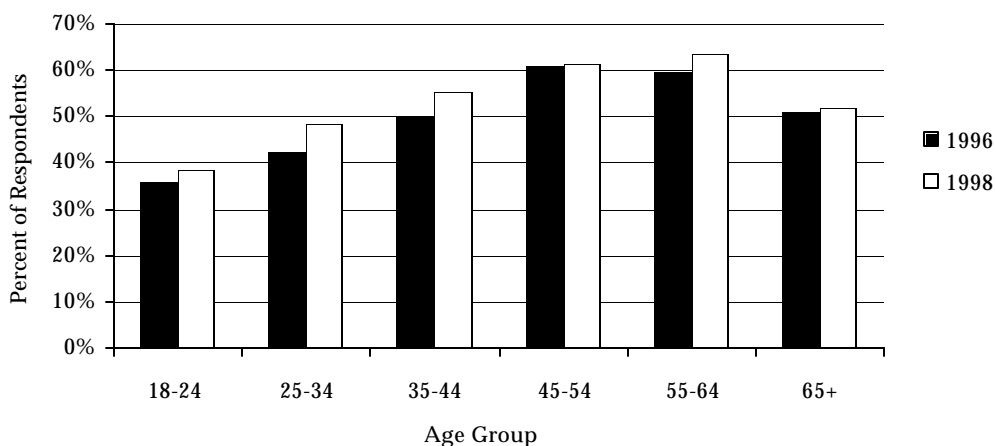
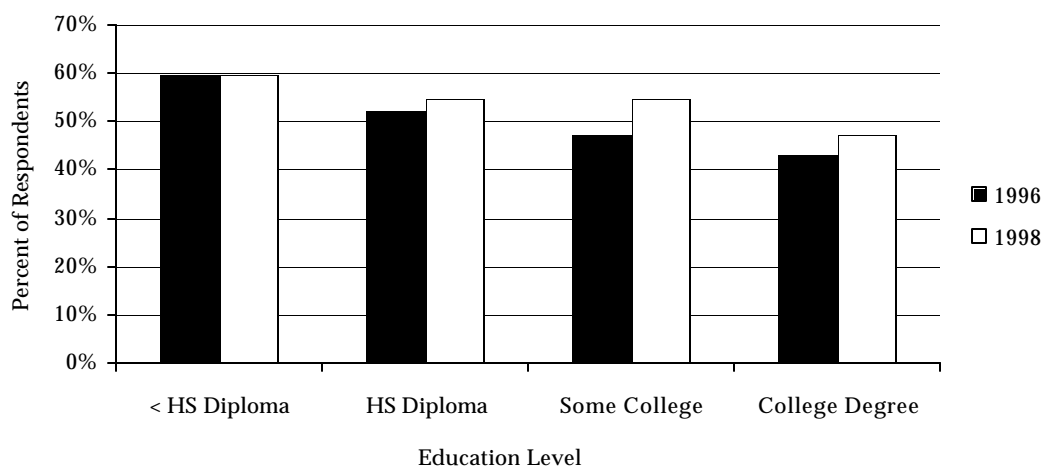


Figure 40. Overweight per Body Mass Index, by Age Group, BRFSS, Nashville, TN, 1996 and 1998



In Nashville, 49% of adult residents were estimated to be overweight or obese in 1996 and 53% in 1998.

Figure 41. Overweight per Body Mass Index, by Education Level, BRFSS, Nashville, TN, 1996 and 1998



The true proportion of the Nashville adult population that is overweight and obese is likely to be higher than the estimates reported here.

Table 6. Age-adjusted¹ Rates of Adult Overweight, Nashville 1998, Tennessee 1996, and U.S. 1999

	U.S. NHANES 1999	TN BRFSS 1996-1998 ²	Nashville BRFSS 1998
Total	61%	50%	53%
Male	^	59%	60%
Female	^	43%	47%
White	^	49%	49%
Black	^	59%	68%

¹Percentages were age-adjusted to the U.S. 2000 Standard Population.

²Data source: National Center for Health Statistics; available at

<http://www.cdc.gov/nchs/statestatsbysexrace.htm>. Accessed on August 23, 2001.

^Data not available

Discussion

While overweight appears to be less common in Nashville than in the U.S., our mortality rates emphasize that obesity and overweight are significant problems in our community. The 2000 mortality statistics show that diabetes, heart disease, stroke, and cancer consistently rank in the top 10 leading causes of death for all race, gender, and adult age groups. Also, research shows that any rates calculated from self-reported data must be considered underestimates, especially in older adults⁶, so the true proportion of the Nashville adult population that is overweight and obese is likely to be higher than the estimates reported here.

Overweight was most prevalent in adults between the ages of 45 - 64 and blacks.

What groups are most in need of intervention or are at highest risk for obesity-related health problems? According to our estimates from the 1998 BRFSS, overweight was most prevalent in adults between the ages of 45-64 and blacks. Blacks were three times more likely to be overweight than the rest of the population. Persons between the ages of 45 and 54 were 34% more likely to be overweight than persons in the other age groups combined and persons between 55 and 64 were 53% more likely to be overweight than the other age groups combined. Obesity reduction campaigns should be targeted to these groups.

Metro Health Department already has two programs that indirectly deal with overweight by targeting associated risk factors and chronic conditions. The Division of Health Promotion's "Walk Nashville Week" is conducted in cooperation with the Community Health and Wellness Team, a community-based volunteer organization. Walk Nashville Week has several activities each year that promote walking in all age groups – grade-school children, sports fans, and the elderly. The Chronic Disease Intervention Program monitors the condition of residents with diabetes and/or hypertension through a case-management plan. Home-visiting nurses and a certified diabetes educator work with patients to improve their understanding of the disease, maximize their utilization of health care options, and teach them how self-management strategies like diet, glucose monitoring, and physical activity can improve their condition.

In the near future, better data will be available to assess overweight and obesity in Nashville. The year 2000 BRFSS concentrates on many high risk council districts and population sub-groups. Also a much larger sample of the community was surveyed than in past years. Data will also be available for a representative sample of 200 Nashville residents who participated in the NHANES 2000. NHANES 2000 will provide several clinic measures on the participants, including height and weight. These sources should allow us to make a better estimation of the true prevalence of overweight in our county.

References

1. Centers for Disease Control and Prevention, National Center for Health Statistics. Health behavior and risk factor data questions [online]. Available at: <http://www.cdc.gov/nchs/datawh/statb/hbrfdes.htm#bmi>. Accessed August 23, 2001.
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6. Kuczmarski MF, Kuczmarski RJ, Najjar M. Effects of age on validity of self-reported height, weight, and body mass index: findings from the Third National Health and Nutrition Examination Survey, 1988-1994. *Journal of the American Dietetic Association*. 2001;101(1):28-34.

Related Indicators

- Air quality
- Environmental tobacco smoke
- Infant mortality
- Leading causes of death
- Cancer incidence
- Economic dimension of health problems

2.2.3 Tobacco Use – Smoking

Background

In 1957, the U.S. Public Health Service declared that “excessive smoking is one of the causative factors of lung cancer.”¹ A few years later the Surgeon General gave more complete evidence of this in the 1964 report on “Reducing the Health Consequences of Smoking”.¹ In the following four decades, the public health and medical communities have learned a great deal more about how smoking harms health. The Centers for Disease Control and Prevention estimate that 1 in 5 deaths in the U.S. is smoking related.² Smoking is known to increase risk of death from several kinds of cancer (especially lung), respiratory conditions, cerebrovascular disease (stroke), and heart disease. Essentially, smoking is the number one preventable cause of death and disease in the U.S.³

Healthy People 2010 provides multiple objectives related to tobacco use. Objective 27-1 is aimed at reducing all forms of tobacco use by adults aged 18 years and older. The tobacco smoking goal is to reduce the percentage of adults who smoke to 12% of the population by 2010. Objective 27-5 focuses on smoking cessation attempts. The goal is for 75% of adults who smoke to have attempted smoking cessation by the year 2010.⁴

To estimate the percent of Nashville residents who smoke, we used data from the 1996 and 1998 BRFSSs. Respondents who reported smoking everyday or some days in the last 30 days were classified as “current smokers”.

Findings

In 1996, 28% of BRFSS respondents could be classified as smokers. In 1998, the percentage dropped slightly to 27% (Figure 42). In both years, more men than women reported smoking. The gap between men and women was small, but it widened slightly in 1998 to

Additional Data

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Data Sources

Metro Public Health
Department: BRFSS

Figure 42. Percent of Respondents Who Were Smokers, Nashville, TN, BRFSS, 1996 and 1998

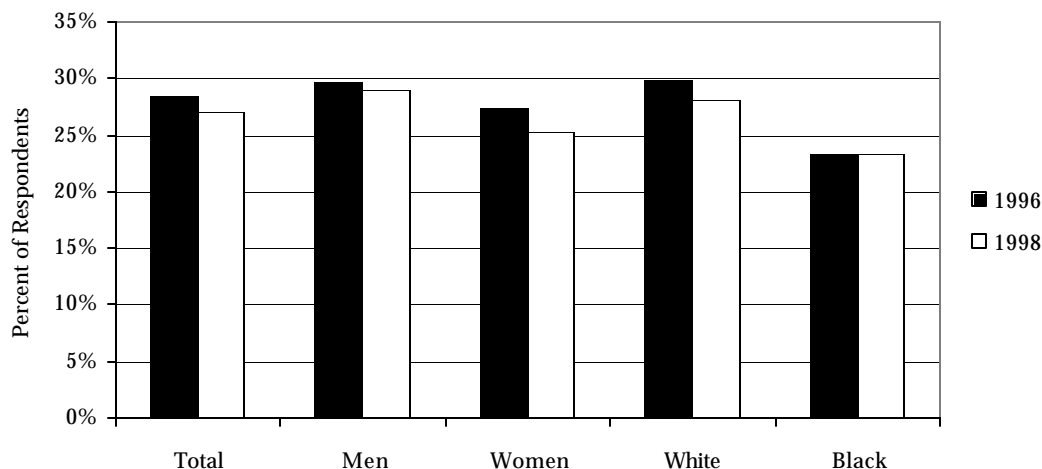
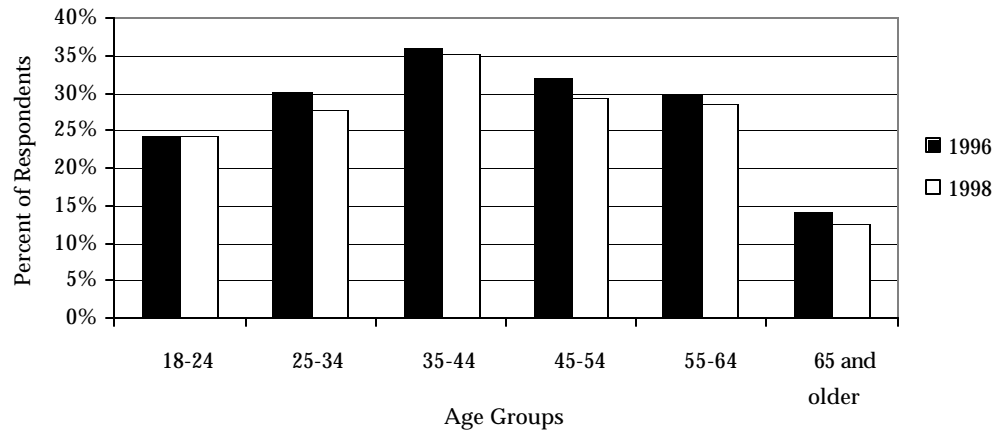


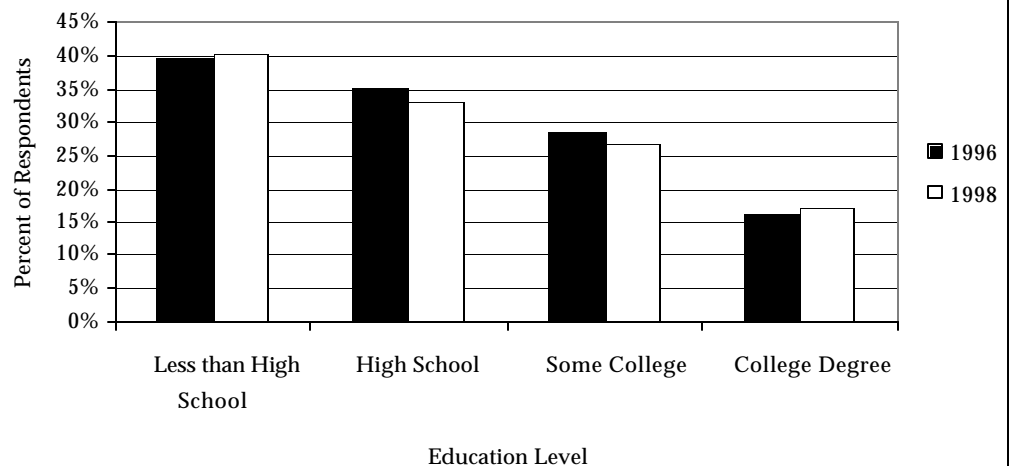
Figure 43. Percent of Respondents Who Were Smokers by Age Groups, Nashville, TN, BRFSS, 1996 and 1998



In Nashville, more than 1 in 4 BRFSS respondents were smokers, and more men than women reported smoking.

29% of men and 25% of women. More whites than blacks were smokers, with approximately 5% fewer blacks being smokers than whites. The percent of respondents who reported smoking was largest in the 35-44 years age group (Figure 43). There was an inverse relationship between smoking and education, with approximately 40% of respondents with less than a high school diploma being smokers, while approximately 17% of college graduates were smokers (Figure 44). The gender, race, age, and education trends in Nashville are all similar to the trends in Tennessee and the U.S.

Figure 44. Percent of Respondents Who Were Smokers by Education Level, Nashville, TN, BRFSS, 1996 and 1998



Overall, Nashville had a higher proportion of smokers in its population than did Tennessee or the U.S.

To directly compare Nashville to Tennessee and the U.S., percentages were age-adjusted to the U.S. 2000 standard population (Table 7). Overall, Nashville had a higher proportion of smokers in its population than did Tennessee or the U.S. The difference between percent of men who smoke and percent of women who smoke was smaller in Nashville than in Tennessee or the U.S. When comparing race, the gap between white and black smokers was smaller in Nashville than in Tennessee, but wider compared to the U.S. rates.

Table 7. Age-adjusted Percentages of Respondents Who Report that They Are Current Smokers, Nashville 1996 and 1998, Tennessee 2000, and U.S. 2000

	Nashville BRFSS 1996	Nashville BRFSS 1998	Tennessee BRFSS 2000	U. S. BRFSS 2000*
Total	28%	27%	26%	23%
Men	29%	28%	28%	24%
Women	28%	25%	24%	21%
White	30%	28%	27%	23%
Black	25%	25%	20%	23%

*Median data from year 2000 BRFSS

Discussion

Tobacco use from smoking in Nashville appears to be equally common in all gender and racial subpopulations. We expect that these estimates of smokers in Nashville are likely to be underestimates. As it has become public knowledge that smoking harms your health, smokers may be less likely to report their habit on a survey. Therefore, it is even more important that the whole of Nashville be the focus of tobacco use reduction. Several educational campaigns and tobacco use initiation prevention programs that appeal to everyone in Nashville are ongoing. Many of these programs are organized by the Smoke-Free Nashville Coalition, a community-based initiative which is facilitated by MPH. Nashville-based educational campaigns tied to national events include Kick-Butts Day and World No Tobacco Day. Smoke-Free Nashville does not provide individual-based cessation counseling, but does offer a comprehensive resources guide of local cessation programs. Prevention programs focused on the adolescent population include no-smoking poster contests and a rewards program for retailers to educate them on the laws against selling tobacco to under-age persons. The Coalition also strives to educate political leaders on the health hazards of smoking, thereby promoting policy change to increase the excise tax on cigarettes and create more smoke-free places.

The National Academy of Medicine has begun an initiative to remove tobacco products from pharmacies as they believe that health products and products that cause ill health and death should not be sold together.

References:

1. U.S. Department of Health, Education, and Welfare. Public Health Service. *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service*. Washington, D.C.: 1964.
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4. U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, in Two Volumes). Washington, D.C.: January 2000.

Related Indicators

- Air quality
- Tobacco use - smoking
- Infant mortality
- Leading causes of death
- Cancer incidence
- Economic dimension of health problems

Additional Data

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Data Sources

Metro Public Health
Department: BRFSS

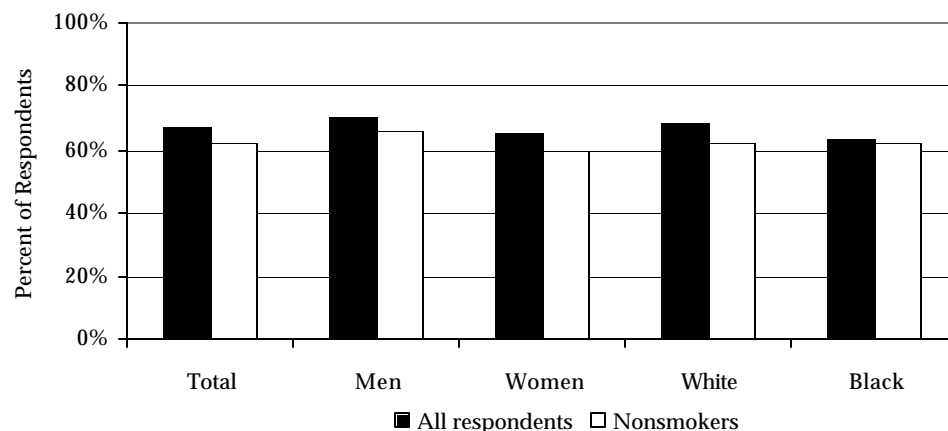
2.2.4 Environmental Tobacco Smoke

Background

Tobacco smoke contains at least 43 chemicals that are documented to cause cancer in humans.¹ These chemicals are obviously dangerous to the smoker, but they also put nonsmokers who are exposed to environmental tobacco smoke (second-hand smoke) at risk. Health problems linked with exposure to environmental tobacco smoke (ETS) include lung cancer, asthma, and heart disease in adults and respiratory infections, low birth weight, and sudden infant death syndrome in children.^{1,2} There are some safe-havens for the nonsmoker – many public places like airports, shopping malls, and office buildings are designated smoke-free. However, significant exposure can still occur in the home, restaurants, and other public places. For children, exposure to ETS is most likely to occur at home. One study estimates that 43% of U.S. children are exposed to ETS in their own homes.³ The Healthy People 2010 target for reducing the proportion of children age 6 and younger who are regularly exposed to tobacco smoke at home is 10% (Objective 27-9). The goal for nonsmokers, including children age 4 and over, exposed to ETS in any location (home, work, public) is 45% (Objective 27-10).

The 1998 Nashville BRFSS surveyed respondents about their exposure to ETS. The study defined ETS or second-hand smoke as smoke exhaled by smokers and smoke that comes from the burning end of a cigarette, cigar, or pipe. The survey also asked if respondents had been exposed to ETS in the past 30 days. For respondents who said they were exposed, they were further asked about where they were exposed – home, work, restaurant, or other. Data from the National Health and Nutrition Examination Survey III (NHANES III), conducted from 1994 to 1998, are used in setting the Healthy People 2010 objectives and offer a comparison population for Nashville data.³ One notable difference in the two surveys is that ETS exposure in the NHANES III is based on a clinical measurement (serum cotinine), while the Nashville exposure is based on a self-report by respondents.

Figure 45. Exposure to Environmental Tobacco Smoke Reported in All Respondents and in Nonsmoking Respondents, BRFSS, Nashville, TN , 1998

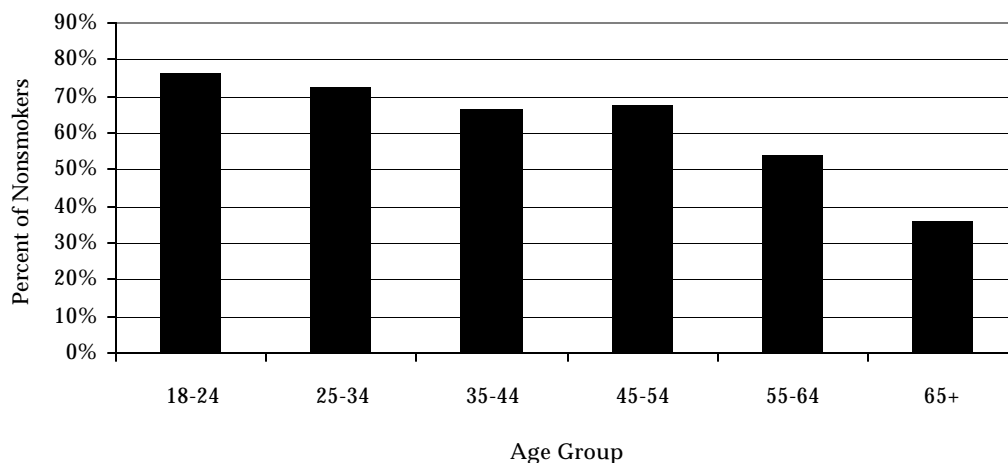


Findings

In Nashville, 68% of all respondents reported exposure to environmental tobacco smoke.

Sixty-eight percent of all respondents reported exposure to ETS (Figure 45) and 63% of nonsmoking respondents reported exposure. Nonsmokers composed 73% of the 1998 Nashville BRFSS. The nonsmokers had similar rates of exposure as the total respondents group when stratified by gender and race. Since smokers, by definition, are exposed to ETS, we will focus on the demographics of the exposed nonsmokers. More men than women nonsmokers were exposed to ETS, 66% and 60%, respectively. Exposure was the same in nonsmoking blacks and whites. Grouping nonsmokers by age, there is a decreasing trend for exposure in the older age groups (Figure 46). Nonsmokers with less than a high school diploma had the lowest rates of reported exposure to ETS of all the education-level groups (Figure 47). Respondents were also asked in what setting they were exposed. They were allowed to give multiple answers. The majority of ETS exposure for nonsmokers was reported to have occurred in restaurants (52%), 29% said they were exposed at work, 23% were exposed at home, and 20% were exposed at locations other than home, work, or restaurants.

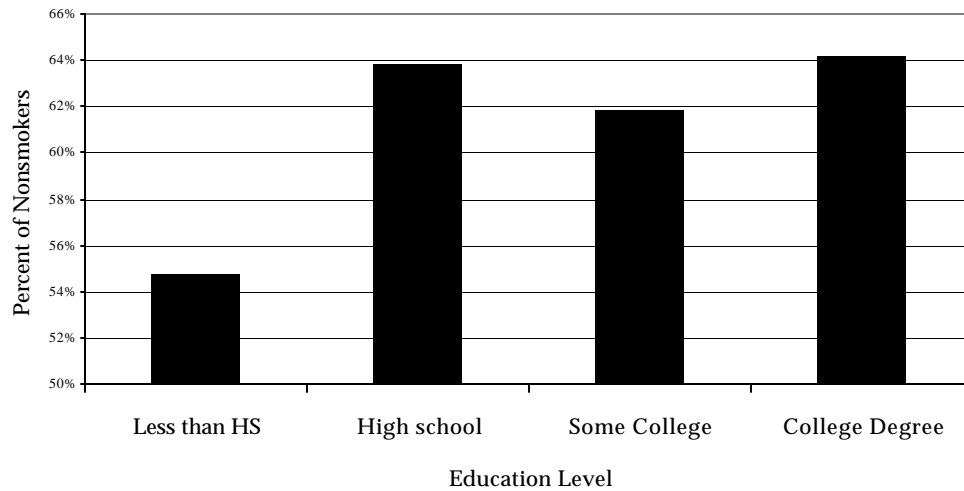
Figure 46. Exposure to Environmental Tobacco Smoke in Nonsmoker Respondents by Age Group, BRFSS, Nashville, TN, 1998



In the U.S., approximately 61% of nonsmoking adults over age 20 were exposed to ETS, according to the National Health and Nutrition Examination Survey III which was conducted from 1988 to 1994. The same data provides an estimate that 68% of children ages 4 to 11 years were exposed to ETS as were 69% of adolescents age 12 to 19. All of these percentages are age-adjusted to the U.S. 2000 standard population. In Nashville, the age-adjusted proportion of nonsmoking adults exposed to ETS is 62%. The trends for gender and age are the same in Nashville and the U.S. There are no estimates of ETS exposure in Tennessee adults, however, the national BRFSS from 1996 estimated that 32.1% of Tennessee children were exposed to ETS in the home. Tennessee had the second highest exposure in the country.

Reducing environmental tobacco smoke exposure is a challenge, especially for children who may have the highest risk for developing health problems.

Figure 47. Exposure to Environmental Tobacco Smoke in Nonsmokers by Education Level, BRFSS, Nashville, TN, 1998



Discussion

Reducing ETS exposure is a challenge, especially for children who may have the highest risk for developing health problems. Passing laws to require that all work sites and public places have smoke-free indoor environments is one solution. Healthy People 2010 incorporates that solution into objectives 27-11, 27-12, and 27-13. However, that does nothing to reduce exposure in the home, the place where children are most often exposed. Perhaps exposure in the home could be addressed by a community-based initiative to educate parents, especially new parents, about the dangers that ETS poses to their children. In Nashville, many of these issues are being addressed by the Smoke-Free Nashville Coalition, a community-based initiative facilitated by MPH. The Coalition encourages many public places to be smoke-free and produces an annual dining guide of smoke-free restaurants. The Coalition has also begun to address the problem of ETS in the home by providing educational materials to new home owners in certain neighborhoods.

References:

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2. California Environmental Protection Agency. *Health Effects of Exposure to Environmental Tobacco Smoke. Final Report*. Sacramento, CA: California Environmental Protection Agency, Office of Environmental Health Hazard Assessment; September 1997.
3. U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, in Two Volumes). Washington, D.C.: January 2000.

Related Indicators

- Educational attainment
- Cancer screening
- Teenbirths
- Prenatal care
- Low birth weight
- Preterm birth
- Sexually transmitted diseases
- Economic dimension of health problems

Additional Data

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Data Sources

Metro Public Health
Department: BRFS

2.2.5 Sexual Behavior

Background

Increasing safe sexual behavior is one of the key ways to reduce the risk for transmission of sexually transmitted diseases (STDs), including infection with the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). Of all STDs, AIDS is by far the most lethal. In the last decade, the AIDS epidemic has been better understood and, subsequently, a large amount of public health resources have been dedicated to behavioral interventions in an effort to reduce the incidence of disease. Both community-level and individual interventions have been effective in increasing condom use and spreading the message about the importance of safe sex in the general population, especially among HIV-infected persons.¹

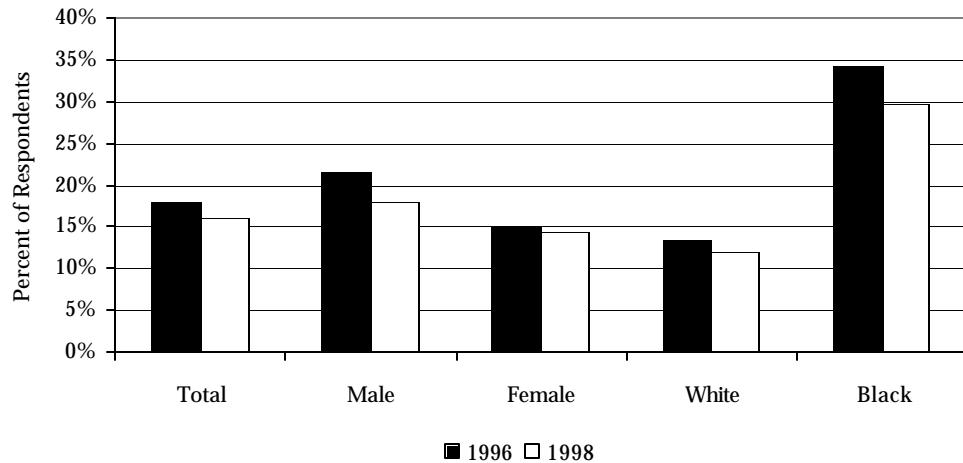
Historically, young men had the greatest risk of morbidity and mortality from HIV/AIDS, but the number of women and infants diagnosed with HIV/AIDS is growing. Beyond gender and age, there is also racial disparity in HIV/AIDS. In Nashville, a higher proportion of blacks die from the disease than whites. HIV-related disease is the 7th leading cause of death among blacks in Nashville in 2000, but the 18th among whites. (See Sections 3.4.3 for information pertaining to STD and HIV/AIDS morbidity.) National data show that Hispanics are a high-risk group as well.

The majority of the Healthy People 2010 objectives for HIV/AIDS are aimed at reducing the incidence, prevalence, comorbidity, and mortality of the disease and increasing awareness in high risk groups. The goal of Objective 13-6 is to increase the proportion of sexually active persons who use condoms to 50%. While we cannot estimate that proportion for the entire sexually active population in Nashville, we can estimate condom use in a portion of the population that recognizes the need for sexual behavior change. Nashville's BRFS in 1996 and 1998 asked questions about sexual behavior with respect to the respondent's knowledge of HIV. We used responses to questions about changes in sexual behavior, choice of monogamous relationships, and condom use to estimate how residents might have changed their risky behavior because of what they know about HIV transmission. In both survey years, the series of sexual behavior questions was preceded by the statement, "due to what you know about HIV", therefore, the answers should be considered specific responses to HIV risk and not general STD risk. Since these answers are all self-reported, we acknowledge that they may be over- or underestimates of actual sexual behaviors in the community.

Findings

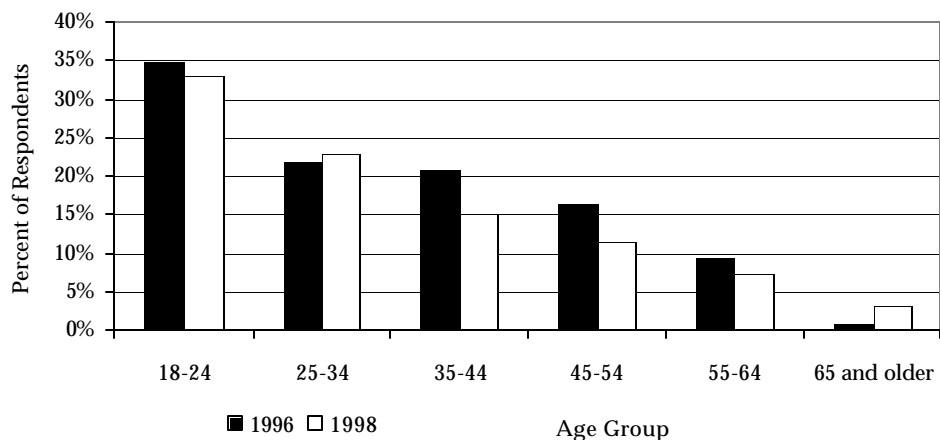
In 1996, 18% of respondents said they had changed their sexual behavior due to their knowledge of HIV (Figure 48). More men than women changed behavior and more blacks than whites changed behavior. After splitting race groups by gender, in whites more men reported change than women, but in blacks more women reported change than men (data not shown). Age group stratification reveals that more young respondents reported behavior change than older ones (Figure 49). Grouping by education showed that fewer respondents on either end of the education spectrum changed behaviors, but those in the middle (high school graduates and those with some college) changed more (Figure 50). In the 1998 survey, slightly fewer respondents reported change in their sexual behaviors (16%). The trends for gender, race, education, and age group were the same in 1998 as in 1996.

Figure 48. Percent of Respondents Who Changed Sexual Behavior Due to Their Knowledge of HIV, Nashville, TN, BRFSS, 1996 and 1998



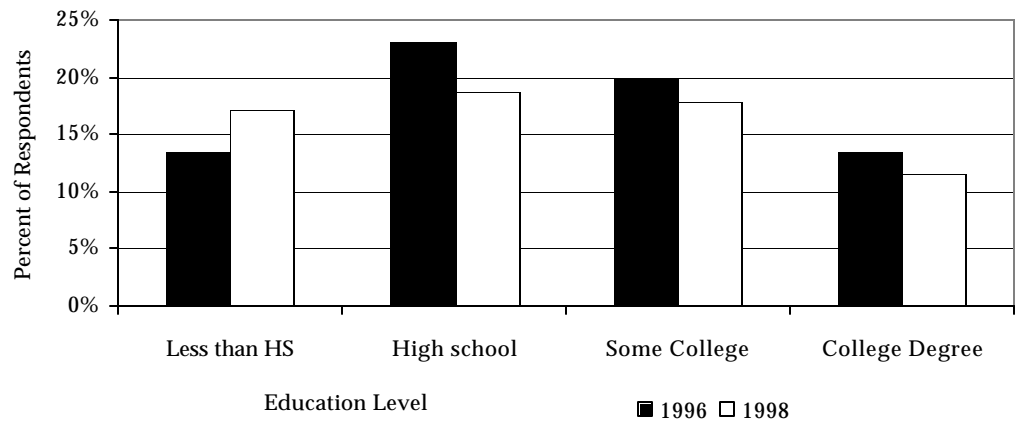
In 1996, 18% of respondents said they had changed their sexual behavior due to their knowledge of HIV.

Figure 49. Percent of Respondents Who Changed Sexual Behavior Due to Their Knowledge of HIV by Age Group, Nashville, TN, BRFSS, 1996 and 1998



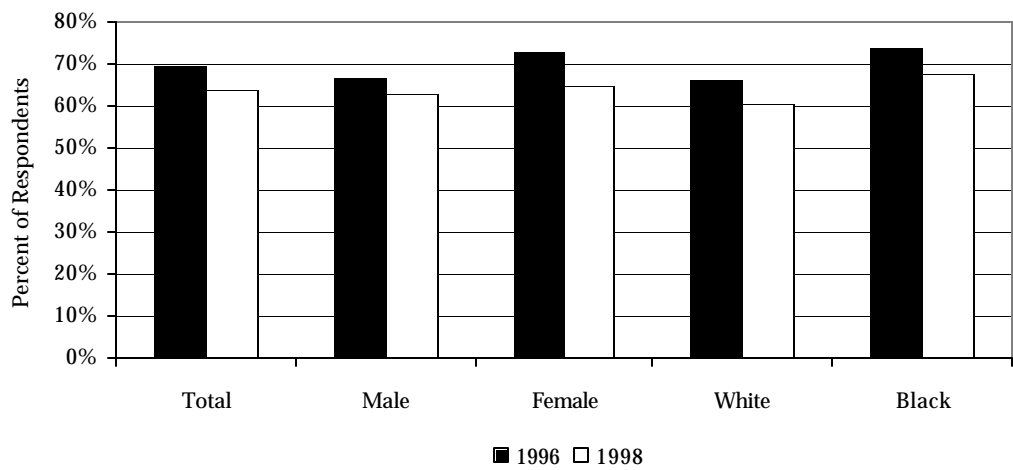
Respondents who reported behavior change were further queried about their protective behaviors, specifically monogamy (only one sexual partner) and condom use. In 1996, 69% reported being in a monogamous relationship. This proportion dropped to 64% in 1998 (Figure 51). In both years, more female than male respondents reported monogamy, as did more blacks than whites. Condom use was reported by 68% of respondents with sexual behavior change in 1996, but only by 48% of respondents in 1998 (Figure 52). In both years, more men than women reported

Figure 50. Percent of Respondents Who Changed Sexual Behavior Due to Their Knowledge of HIV by Education, Nashville, TN, BRFSS, 1996 and 1998



In both 1996 and 1998, more female than male respondents reported monogamy, as did more blacks than whites.

Figure 51. Monogamous Relationships in Respondents Who Reported Sexual Change, Nashville, TN, BRFSS, 1996 and 1998



condom use. The difference between black and white groups was approximately the same in 1996 and 1998, with more blacks reporting condom use than whites. Condom use was more prevalent in younger age groups, with the highest reported use among 18 to 24 year olds (Figure 53).

Figure 52. Condom Use in Respondents Who Reported Change in Sexual Behavior, Nashville, TN, BRFSS, 1996 and 1998

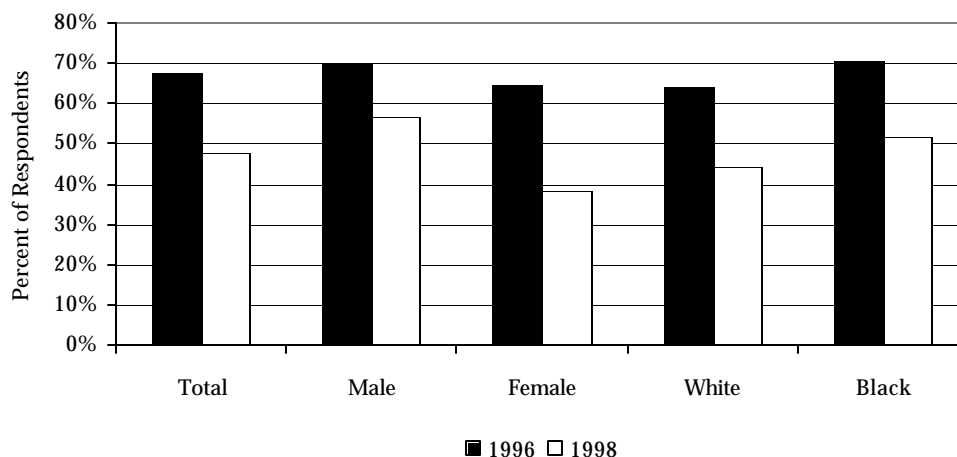
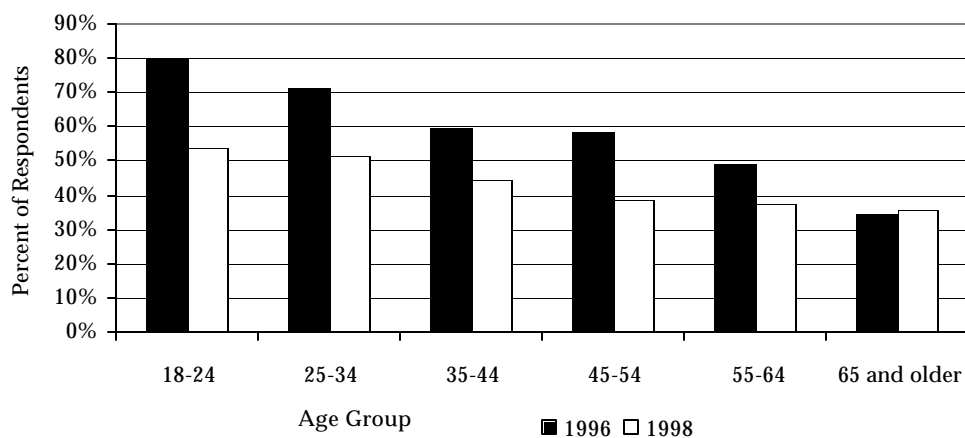


Figure 53. Condom Use in Respondents Who Reported Change in Sexual Behavior by Age Group, Nashville, TN, BRFSS, 1996 and 1998



The goal of Healthy People 2010 objective 13-6 is to increase the proportion of sexually active persons who use condoms to 50%.

Unmarried Men's Use of Condoms

Unmarried men are considered to be one of the most at-risk groups for HIV. In 1996, 73% of unmarried male respondents who reported sexual behavior change also reported using condoms. In 1998, only 60% reported condom use. In both years, more black males reported condom use than whites. The age-trend was also the same in 1996 and 1998, with more men in the younger age groups reporting condom use than men in the older age groups. In 1996, condom use appeared to be similar in all education-level groups, however, in 1998 only 41% of unmarried men with less than a high school diploma used condoms, while 68% with a college education did.

The proportion of Nashville's population that changed sexual behavior appears to be larger than that of Tennessee and the U.S. (Table 8). The 1998 Nashville age-adjusted percentage of BRFSS respondents who changed their sexual behavior as a result of their knowledge of HIV was 15%, while only 11% of Tennesseans did. When specific behaviors are considered, Nashville had smaller percentages of the population reporting monogamy and condom use than did Tennessee or the U.S.

Table 8. Age-adjusted* Percent of Respondents Who Reported Sexual Behavior Changes, BRFSS, Nashville 1996 and 1998, Tennessee 1997, and U.S. 1997

	Nashville, 1996	Nashville, 1998	Tennessee, 1997	U.S. 1997 **
<i>Changed Sexual Behavior</i>				
Total	17%	15%	11%	10%
Male	20%	17%	12%	11%
Female	15%	14%	10%	9%
Black	30%	27%	24%	25%
White	13%	12%	8%	8%
<i>Monogamy in Those Who Changed Sexual Behavior</i>				
Total	68%	61%	85%	80%
Male	72%	63%	86%	78%
Female	68%	56%	84%	81%
Black	72%	70%	87%	82%
White	65%	54%	86%	78%
<i>Condom Use in Those Who Changed Sexual Behavior</i>				
Total	59%	44%	63%	56%
Male	56%	41%	66%	58%
Female	56%	36%	60%	54%
Black	59%	49%	61%	56%
White	57%	39%	63%	55%

* Age-adjusted to the U.S. 2000 standard population.

** U.S. percents represent the median values for the 50 states, District of Columbia, and Puerto Rico

Discussion

As would be expected, the BRFSS data suggest that there is a need for community-based education on the harms of risky sexual behavior. MPHD's efforts to combat the spread of STDs focus on the entire population. MPHD supports and facilitates the community-based STD Free! initiative which consists of volunteers from the faith community, law enforcement, local schools and universities, health care providers, health care facilities, and social service agencies. STD Free! has ongoing educational activities in the community and special annual events such as the STD Free! Haunted House. The Haunted House has received national acclaim for its educational methods. The majority of visitors are teenagers and young-adults. Visitors to the Haunted House see graphic examples of the risks and potential outcomes associated with various STDs such as syphilis, chlamydia, and gonorrhea. The event also offers free testing for HIV and syphilis.

Reference:

1. U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, in Two Volumes). Washington, D.C.: January 2000.

The proportion of Nashville's population that changed sexual behavior appears to be larger than that of Tennessee and the U.S.

Metro Public Health Department supports and facilitates the community-based STD Free! initiative which consists of volunteers from the faith community, law enforcement, local schools and universities, health care providers, health care facilities, and social service agencies.

Related Indicators

- Sexual behavior
- Sexually transmitted diseases
- Tobacco use - smoking

2.2.6 Substance Abuse and Illicit Drug Use

Background

Substance abuse and use of illicit drugs present a plethora of public health problems to drug users and the community as a whole. Substance abuse and illicit drug use are associated with the spread of many communicable diseases – tuberculosis, sexually transmitted diseases, such as Acquired Immunodeficiency Syndrome (AIDS), syphilis, and hepatitis – as well as non-traditional public health issues of violence and crime.^{1, 2} Drug abuse may foster a poor environment for the children, born and unborn, of the abusers and may also be an indicator of mental illness. Drug abusers place a significant burden on the medical community. Drug-related emergency hospital visits are at historically high rates.² The main reason for these visits is drug overdose (49%). The public health community also has the responsibility of providing effective addiction treatment and counseling services. Drug abuse is a large contributing factor to injuries and premature death. However, there is a decreasing trend in drug-related mortality in both the nation and Nashville (Table 9). In the United States, the age-adjusted drug-induced mortality rate went from 7.0 per 100,000 population in 1999 to 5.8 in 2000. In Nashville, the age-adjusted rates fell from 9.9 per 100,000 population in 1999 to 7.4 in 2000.

Table 9. Drug-induced Mortality Rates per 100,000 Population, Age-adjusted*, Nashville and U.S., 1999 and 2000

	Nashville 1999	Nashville 2000	U.S. 1999	U.S. 2000**
Total	9.9	7.4	7.0	5.8
Gender				
Males	15.2	9.9	9.6	
Females	5.6	5	4.4	
Race				
White	10.7	8.3	6.9	
Black	7.7	6.3	9.5	

*Rates were age-adjusted to the United States 2000 standard population.

**National mortality rates for 2000 are preliminary, not final.

The Healthy People 2010 Objective 26 - 10c for the nation is to reduce the proportion of adults (aged 18 years and older) using illicit drugs from 5.8% in 1998 to 3.0% in 2010.³ Annual surveys of the population are done on the national level by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services. However, no surveys are done on the local level. Because of the association between drug abuse and crime, we used arrests for drug abuse violations in Nashville as a proxy for the prevalence of illicit drug use. There are several limitations of using arrests to estimate the prevalence of drug use. The results could produce an underestimate because not all drug users get arrested, or it could be an overestimate because some drug users may be arrested multiple times in a year – unique individuals are not identified when counting number of arrests.

Data Sources

Metropolitan Nashville
Police Department

Findings

Arrests for drug abuse violations in Nashville accounted for 15% of all arrests in 2000 (Table 10). The majority of persons arrested for drug abuse violations were men (77%). There were more blacks (61%) arrested on these charges than whites (39%). Considering the arrests by age of the offender, nearly two-thirds (63%) of those arrested were under age 35 at the time of arrest. Gender, race, and age-distribution data on arrests are not currently available for 2000 on the state level; however, they are available on the national level. Nashville, like the U.S., had more men arrested on drug abuse violations than women (Table 10). However, the race distribution was different. The majority of drug abuse arrests in the U.S. were in whites (63%), while in Nashville, the majority were in blacks (61%). The age distributions of Nashville and U.S. adult drug abuse violations were similar, with more than 60% being adults under age 35.

Table 10. Adult Arrests (Age 18 and Older) for Substance/Drug Abuse Violations, Nashville, Tennessee, and U.S., 2000

	Nashville 2000¹	Tennessee 2000²	U.S. 2000²
Arrests for drug abuse violations	7,515	15,998	907,754
Total number of arrests	49,622	151,419	7,556,678
Percent of total arrests	15%	11%	11%
<i>Percentage Distribution of Drug Abuse Arrests by Gender, Race, and Age</i>			
<i>Gender</i>			
Males	77%	NA ³	82%
Females	23%	NA	18%
<i>Race</i>			
White	39%	NA	63%
Black	61%	NA	35%
<i>Age Groups</i>			
18-24 years	32%	NA	41%
25-34 years	31%	NA	28%
35-44 years	28%	NA	22%
45-54 years	8%	NA	7%
55-64 years	1%	NA	1%
65 years or older	0%	NA	0%

¹Metropolitan Nashville Police Department.

²Uniform Crime Reports for 2000. <http://www.fbi.gov/ucr/00cius.htm>

³Rates not available for Tennessee.

Arrests for drug abuse violations in Nashville accounted for 15% of all arrests in 2000. The majority of drug abuse arrests in the U.S. were in whites (63%) , while in Nashville, the majority were in blacks (61%).

There appears to be a trend of an increasing percentage of drug abuse violations in Nashville. In 1997 only 9% of adult arrests were from drug abuse violations, in 1998, 10% were from drug abuse violations.⁴ In 1999, the percentage dropped to 8%, but it nearly doubled in 2000 to 15% of arrests. Comparing Nashville to Shelby County (Memphis) and Knox County (Knoxville), we find that the percentage of arrests due to drug abuse violations were similar and also increasing. In Shelby County, 9% of adult arrests were from drug abuse violations in 1997, and 10% in 1998.⁴ In Knox County, 8% of adult arrests were from drug abuse violations in 1997, and 11% in 1998.⁴ Nashville has a higher percentage of arrests from drug abuse violations than the nation and Tennessee (Table 10). As we saw in Nashville and Shelby and Knox Counties, the state has experienced an increase in arrests for drug abuse violations – in 1999, it was only 9% of total arrests, but this percentage rose to 11% in 2000.

Discussion

In Nashville, drug-induced mortality is decreasing, but arrests from drug abuse violations are increasing. While these trends seem to be conflicting, there may be reasonable explanations for both of them. Perhaps the simplest interpretation is that there are growing numbers of substance abusers, while addiction treatment programs are succeeding in keeping at least some of them from premature death. Clearly there is an opportunity for the public health community to improve the welfare of our county in many ways by treating drug abuse. Research suggests that addiction treatment may be more effective if provided in conjunction with basic medical services, especially for individuals with psychiatric conditions.⁵ Without significant increase in costs to the medical or addiction treatment programs, these individuals were more successful in quitting drugs and went longer periods without a relapse to drug use. The Opening Doors program at MPHD follows a similar treatment model. It offers case management for both the patient's addiction and medical problems. It operates under the philosophy that addiction is a primary illness that requires both addiction treatment and medical care and that untreated patients might otherwise be arrested, institutionalized, or die prematurely. The goal of this program is to assist county residents who have no means of paying for treatment services.

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3. U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, in Two Volumes). Washington, D.C.: January 2000.
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Related Indicators

- Bicycle helmet use
- Leading causes of death
- Economic dimension of health problems

2.2.7 Safety Belt Use

Background

The goal of promoting and mandating safety belt use is to reduce injuries and fatalities in motor vehicle accidents. Motor vehicle accidents (MVAs) are a leading cause of unintentional accidental deaths, accounting for 39% of all accidental deaths in 1999 in Nashville, TN. Nashville's age-adjusted mortality rate from MVAs is similar to that of the United States (US) – 1999 Nashville: 16.0 per 100,000; 1999 U.S.: 15.5 per 100,000.

Safety belt use in Tennessee has been mandated by law since 1986 as secondary law and became primary law in July of 2000. The Tennessee Health Status Report of 1999 reported that 66% of Tennessee adults always wear safety belts.¹ In the United States, 69% of the adult population reports always wearing a seat belt.² The U.S. Department of Health and Human Services' *Healthy People* report states that the goals for nationwide use of safety belts are 85% by the year 2000 and 92% by the year 2010 (Objective 15 - 19).³ To estimate Nashville's progress towards the national goal, we estimated use of safety belts in adults and children and the use of child safety seats from safety questions in the 1996 and 1998 Nashville BRFSS.

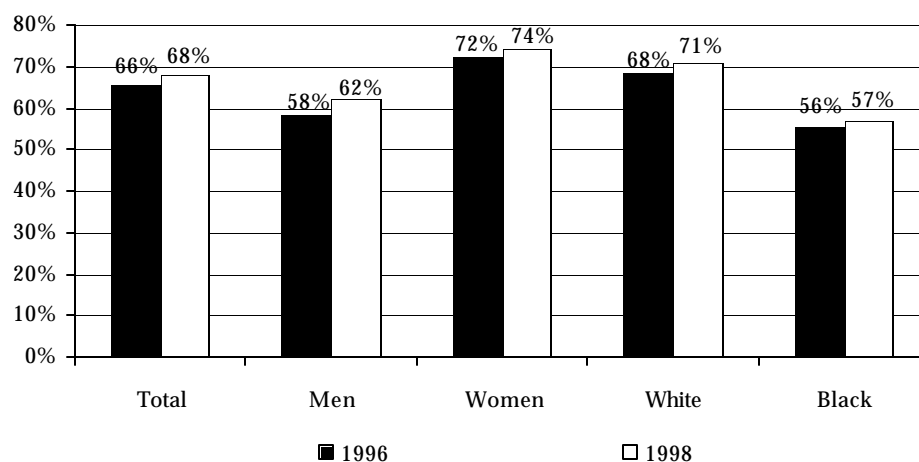
Findings**Adult Safety Belt Use**

In 1996, 66% of Nashville's adults reported always using safety belts (Figure 54). This percentage increased slightly to 68% in 1998. From 1996 to 1998, rates of use rose for men and women, whites and blacks. However, women were consistently more likely to wear safety belts than men – 72% of women compared to 58% of men in 1996 and 74% of women compared to 62% of men in 1998. Blacks had lower rates of safety belt use than whites and also increased use less than whites from 1996 to 1998. Sixty-eight

Additional Data

Appendices
pages D-37 - D-38

**Figure 54. BRFSS Respondents Who Always Use Safety Belts,
Nashville, TN, 1996 and 1998**

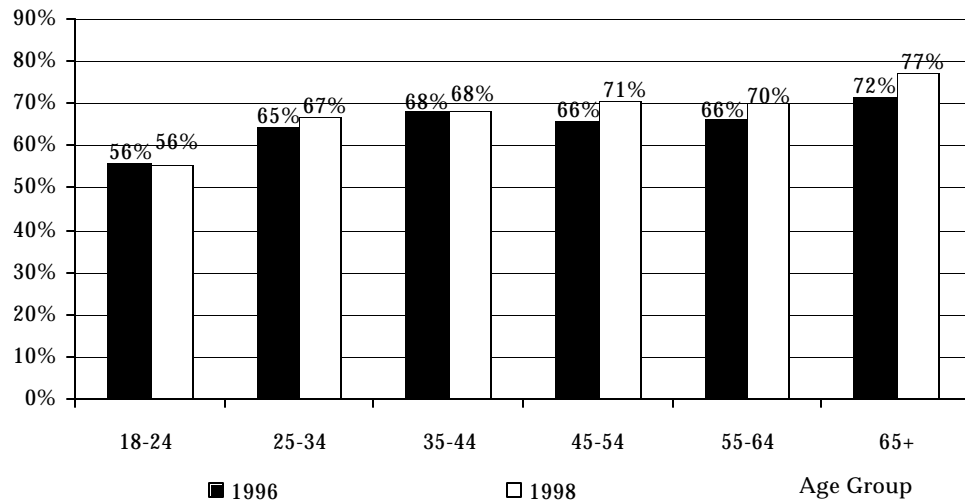


Data Sources

Metro Public Health
Department: BRFSS

percent (68%) of whites wore safety belts in 1996 compared to 56% of blacks. In 1998, 71% of whites always wore safety belts, compared to 57% of blacks. Considering safety belt use by age groups reveals that use is more common in older age groups (Figure 55). In 1996, safety belt use ranged from 56% in the 18-24 year old group to 72% in the 65+ age group.

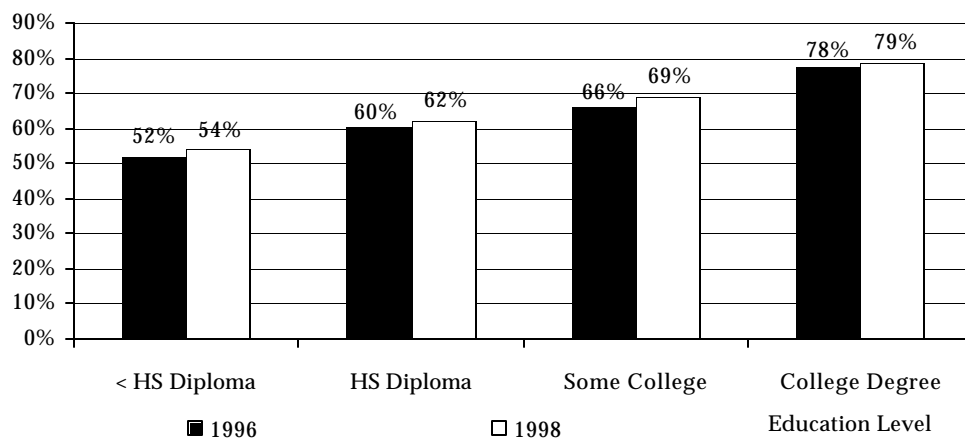
Figure 55. BRFSS Respondents Who Always Use Safety Belts, By Age Group, Nashville, TN, 1996 and 1998



In 1996, 66% of Nashville's adults reported always using safety belts. This percentage increased slightly to 68% in 1998.

In most age groups, there was an increase in use in 1998. The largest increases were of 5% in the 45-54 and 65+ age groups. Education level also appeared to influence safety belt use. Overall, safety belt use was higher in groups with higher education (Figure 56). In

Figure 56. BRFSS Respondents Who Always Use Safety Belts, by Education Level, Nashville, TN, 1996 and 1998



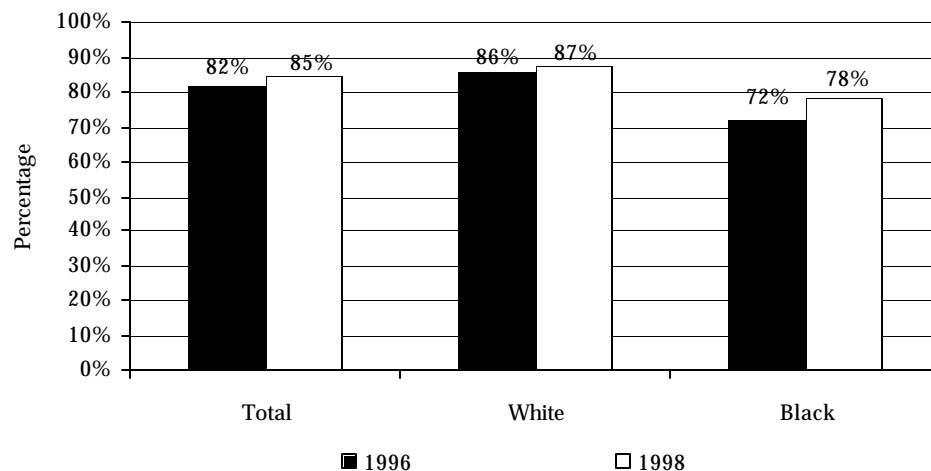
1996, the percentage of persons who reported always wearing seat belts went from 52% in persons with less than a high school diploma, to 60% in those with a high school diploma, to 66% in those with some college, to 78% in those with a college degree (Figure 56). There was an average two percentage points increase in each education group in 1998: 54% of residents with less than a high school diploma always wore safety belts, while 79% of those with a college degree did.

Nashville adult residents reported much higher rates of safety belt (and safety seat) use for children under age 16 in their households than they did for themselves.

Child Safety Restraint Use

Nashville adult residents reported much higher rates of safety belt (and safety seat) use for children under age 16 in their households than they did for themselves. In 1996, 82% reported children always wear safety belts or are restrained in child safety seats (Figure 57). This percentage rose to 85% in 1998. Rates were higher in whites than blacks for both years – 1996: whites 85%, blacks 72% and 1998: whites 87%, blacks 78%. The education level of adults in Nashville appears to be associated with use of child safety restraints. In 1996, 68% of persons with less than a high school diploma used child safety restraints, compared to 89% of respondents with a college degree (Figure 58). In 1998, the percentages rose in most education groups. The rate increased 11 percentage points in respondents who did not finish high school, and rose 4 points in respondents who completed college.

Figure 57. BRFSS Respondents Who Always Use Child Safety Seats or Belts, Nashville, TN, 1996 and 1998



Comparison of Nashville to the U.S.

Nashville data were age-adjusted to the U.S. 2000 standard population for comparison with the U.S. 1997 BRFSS results (Table 11). Comparing the adjusted rates for always using safety belts, we find that in 1996 Nashville rates were consistently lower than the U.S. rates. The largest difference was in safety belt use for blacks. In 1998, Nashville rates were very close to those of the U.S., but the rate for blacks was still lower than the U.S. rate. Reported use of safety restraints for children under age 16 in Nashville was

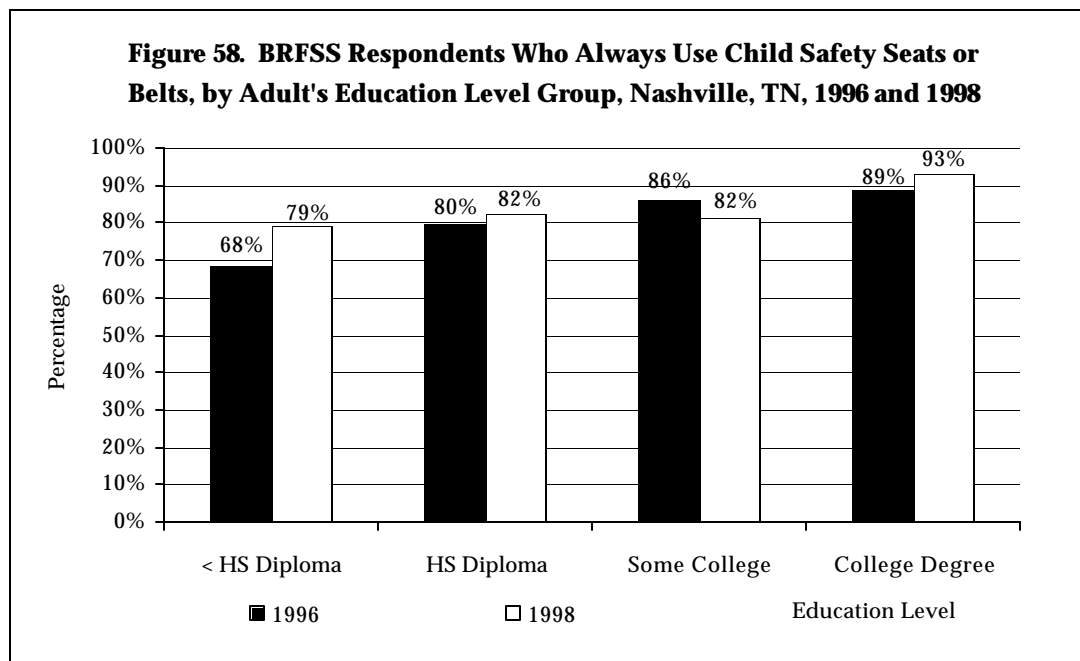


Table 11. Age-adjusted Rates* of Safety Belt Use, Nashville 1996 and 1998 and U.S. 1997

Population	U.S. 1997 BRFSS	Nashville 1996 BRFSS	Nashville 1998 BRFSS
Total	69%	66%	69%
Male	62%	59%	62%
Female	75%	72%	74%
White	70%	68%	71%
Black	63%	56%	59%

*Age-adjusted rates are based on the age distribution of the U.S. 2000 standard population.

Table 12. Age-adjusted Rates* of Child Safety Restraint Use in Nashville 1996 and 1998 and U.S. 1997

Population	U.S. 1997 BRFSS	Nashville 1996 BRFSS	Nashville 1998 BRFSS
Total	85%	83%	83%
Male	85%	83%	86%
Female	85%	84%	81%
White	87%	88%	84%
Black	82%	70%	80%

*Age-adjusted rates are based on the age distribution of the U.S. 2000 standard population.

slightly lower than the rates in the U.S. (Table 12). The biggest difference in Nashville was that the 1996 rate for blacks was 12 percentage points lower than the U.S. rate. Nashville's black rate improved in 1998, with only a 2 point differential between Nashville and the U.S.

Discussion

How do we compare to U.S. and to Healthy People 2000 and 2010 goals? We have not reached the 85% Healthy People 2000 goal, and we have much farther to go to reach the Healthy People 2010 goal of 92% safety belt use. The race, gender, age, and education trends in the Nashville data are similar to those reported by more in-depth safety belt use studies.⁴ While it is promising that Nashville's safety belt use is nearly the same as the rates for the U.S., we must note the potentially unreliable nature of the data since it comes from self-reports instead of direct observation. Studies have been done to observe, first-hand, whether car drivers and passengers wear seatbelts.^{5,6} The results from these studies tell us that seat belt use can be road-specific – people traveling on interstate highways are more likely to wear safety belts than people traveling on city streets.⁵ Some observations from these studies support the findings we have from our survey. They find that more drivers (as opposed to passengers), more women, and more people age 25 or older wear safety belts.⁵ Recent research done by the University of Tennessee Transportation Center found that residents in urban counties wore safety belts more often than rural county residents.⁶

The three groups that require targeted interventions to increase safety belt use rates are blacks, people under age 25, and people without a college education. Many programs to promote safety belt usage in Nashville and Tennessee are already in place. For over a decade, MPH D has promoted child safety seat usage by giving away car seats to parents of limited economic means. On July 1, 2001, a new Tennessee law took effect which makes it mandatory for all passengers between ages 4 and 17 to wear safety belts when riding in any seat of a vehicle operated by a person with a learner's permit or intermediate driver license. To enforce this law and existing safety belt use laws, Tennessee is participating in the "Click It or Ticket" program.⁶ Nationally, the U.S. Department of Transportation and Nashville's Meharry Medical College joined efforts in a nationwide initiative to increase safety belt use in blacks.⁷

References:

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5. Wells JK, Williams AF, Lund AK. Seat belt use on interstate highways. *American Journal of Public Health*. 1990;80:740-742.
6. Tennessee Department of Transportation. Click It or Ticket 2001. Available at: <http://www.tdot.state.tn.us/ClickItorTicket/>. Accessed May 22, 2001.
7. Meharry Medical College. Achieving a Credible Health and Safety Approach to Increasing Seat Belt Usage Among African Americans. 1999.

The three groups that require targeted interventions to increase safety belt use rates are blacks, people under age 25, and people without college education.

Related Indicators

- Safety belt use
- Leading causes of death
- Economic dimension of health problems

Additional Data

Appendices
page D-39

Data Sources

Metro Public Health
Department: BRFSS

2.2.8 Bicycle Helmet Use

Background

Promoting bicycle helmet use is part of the public health community's effort to reduce morbidity and mortality from all types of injuries. Bicycle helmets can protect cyclists from head injury and are required for children by Tennessee and Nashville laws.^{1,2} In Nashville, all persons under 16 years of age must wear a helmet when riding a bicycle. Public health recommendations from federal agencies call for persons of all ages to wear helmets, but emphasize that children under age 15 are the primary target group for the recommendations.³ The majority of children in the United States ride bicycles, but their rate for use of helmets is lower than that of adults. The National Highway Traffic Safety Administration estimates that bicycle helmet use could prevent 39,000 to 45,000 head injuries in children between the ages of 4 to 15.⁴ They also identify children under age 14 as five times more likely to be injured when riding a bicycle than older riders.

The national goal for bicycle helmet use was 50% by the year 2000.⁵ In the Healthy People 2010 goals, it is not the percentage of riders that is targeted, but the number of states with laws requiring bicycle helmets for bicycle riders (Objective 15-24). The goal is that all states and the District of Columbia make bicycle helmet use mandatory for all cyclists.⁶ In 1999, only 15 states had helmet laws for cyclists under age 18 years or younger, however, this does not account for the county and city governments that may have helmet laws. In this respect, Nashville is already partway to achieving the goal since it has a youth bicycle helmet law. To measure the public health effectiveness of the law, we need to estimate the use of bicycle helmets by the youth of Nashville. In the 1996 Behavioral Risk Factor Surveillance Survey (BRFSS), adults contacted for the survey were asked if children in their households, aged five to 15, wore bicycle helmets when riding a bicycle. We recognize that this estimate may be biased, and possibly an overestimate, since it comes from self-reported data and not from direct observation.

Findings

Thirty-one (31%) percent of households contacted for the 1996 Behavioral Risk Factor Survey reported that their children aged five to 15 always wore helmets when riding bicycles. There was a difference of approximately 9 percentage points between blacks and whites, with whites reporting a rate of 34% use and blacks 25% (Figure 59). Considering the adult respondent's educational attainment, we found that adults with higher levels of education reported higher rates of bicycle helmet use for children (Figure 59). It ranged from 25% in those with less than a high school diploma (Less than HS Diploma) to 38% in those with a Bachelor's degree.

The 1999 nation-wide BRFSS data place the median rate for youth bicycle helmet use at 33% for the United States, with rates of 35% for whites and 30% for blacks (Table 13). Nashville data, after age-adjustment to make them comparable to the U.S. data, showed that our rate of 32% was similar to the national data, however the racial disparity was greater in Nashville than for the nation. After age-adjustment, 36% of whites reported children always wear bicycle helmets, compared to 20% of blacks. In the state of Tennessee, 1999 rates were higher than both Nashville and the U.S. median. Forty-two percent of respondents to the Tennessee BRFSS reported that children in their household always wore bicycle helmets. There also appeared to be only a small difference between white and black Tennesseans –bicycle helmet use reported by whites was 42% and 40% by blacks.

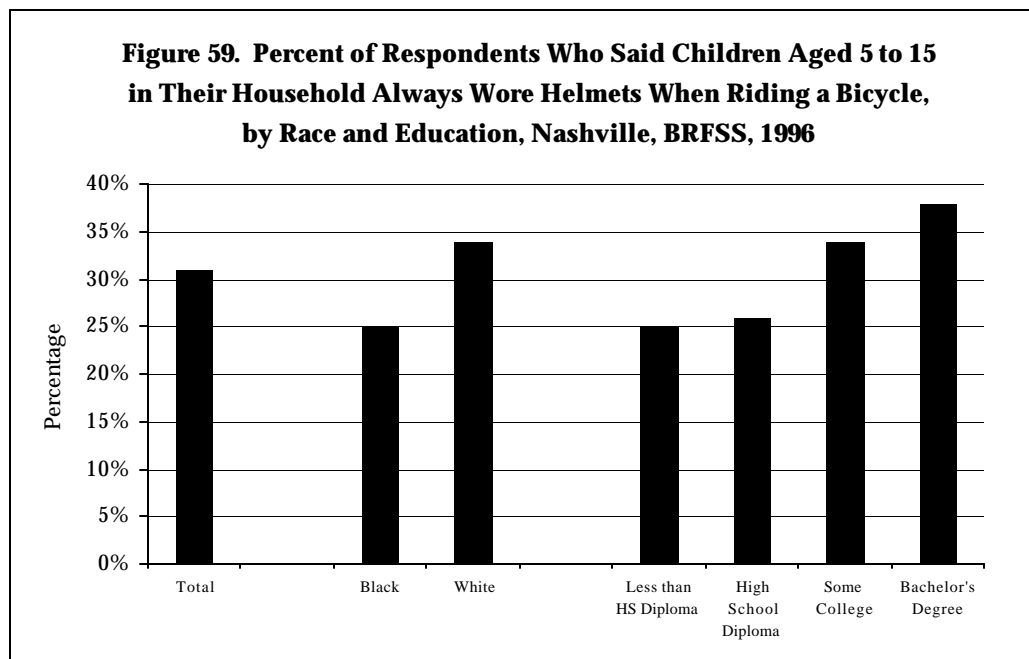


Table 13. Age-adjusted Percent of Children Aged 5 to 15 Years Reported to Always Wear Helmets When Riding Bicycles, Nashville 1996, Tennessee 1999, and U.S. 1999

	U.S. 1999 BRFSS	Tennessee 1999 BRFSS	Nashville 1996 BRFSS
Total	33%	42%	32%
White	35%	42%	36%
Black	30%	40%	20%

Discussion

As of 1996, Nashville had not reached the national goal of 50% bicycle helmet usage. Nashville has a youth bicycle helmet law, but the law is not enough to get children to wear bicycle helmets. Research by other groups on barriers to helmet use has identified cost, wearability of helmets, lack of knowledge about helmet effectiveness, and peer-pressure among children as key issues for intervention.¹ Educational interventions for parents should depend on the parental education level and the economic position of the community. Studies have found that in high-income neighborhoods, a little parental education can go a long way to increasing bicycle helmet use in children.⁷ In such neighborhoods, school-based programs may be sufficient. In Nashville, the high-risk portion of the community appears to be blacks and parents who have not obtained education beyond high school. Since 1997, the Division of Health Promotion of MPHD has made efforts to address this problem by distributing bicycle helmets to children from low-income families. Bicycle rodeo events are held at day care and Head Start centers, targeting children who range in age from 3 to 5 years old. Health Promotion staff also give educational lectures on child safety which include emphasis of the need for children to use bicycle helmets. These lectures are typically directed to adults who work with children in schools, day care centers, or as social workers. Still, the long-term effectiveness of most bicycle helmet

promotion programs has been poor.³ The best solution may be for the public health community to work in concert with community groups so that more of the public is reached with this important information.

References:

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As of 1996, Nashville had not reached the national goal of 50% bicycle helmet usage. Nashville has a youth bicycle helmet law, but the law is not enough to get children to wear bicycle helmets.

Related Indicators

- Sexual behavior
- Leading causes of death
- Cancer incidence

Additional Data

Appendices
pages D-30, D-41, D-42

2.2.9 Cancer Screening

Background

Cancer is the second leading cause of death in Nashville. In the year 2000 alone, cancer claimed 9,730 years of potential life from our residents (see Section 3.3.2 for more information). Breast, cervical, and colon cancers were responsible for 18% of the cancer deaths in 2000. Effective screening measures for early detection are readily available for these three types of cancer. The purpose of cancer screening tests such as mammograms, Pap tests, and digital rectal exams are to prevent deaths and improve treatment outcomes through early detection. National recommendations are for all women age 18 and older to have annual pap tests and women over the age of 40 to have annual mammograms. The recommendation for colon cancer screening has recently been revised from digital rectal exams (DRE) to a combination of a fecal occult blood test and sigmoidoscopy for both men and women over age 50.¹

Healthy People 2010 includes goals for reducing cancer deaths and increasing the use of cancer screening procedures. The mortality-reducing targets for 2010 are to reduce female breast cancer deaths to 22.3 per 100,000 population (objective 3.3), to reduce cervical cancer deaths to 2 per 100,000 population (objective 3.4), and to reduce colorectal cancer deaths to 13.9 per 100,000 population (objective 3.5) (all rates are age-adjusted).² The female-specific cancer screening targets for 2010 are to increase the percentage of women, ages 18 and over, who have ever had a Pap test to 97% (objective 3.11a), to increase those who have had a Pap test in the last 3 years to 90% (objective 3.11b), and to increase the percentage of women, ages 40 and over, who received a mammogram within the last 2 years to 70% (objective 3.13).² The target for colorectal cancer screening in both males and females is to increase the percentage of adults who have ever received a sigmoidoscopy to 50% by 2010 (objective 3.12b).² The Healthy People 2000 target for DRE was for 40% of people aged 50 and older to have this exam annually.³

In this report, we estimated adherence to cancer screening recommendations via questions asked in the Nashville BRFSS of 1996 and 1998. In 1996, the questions on mammography and Pap tests were part of a long list of women's health questions. The female respondents were also asked why they had the tests done and with what frequency. In 1998, the mammography and Pap test questions were much more limited. Questions on DREs were the same both years, except in 1996 all respondents were asked the question, but in 1998 only males were asked.

Findings

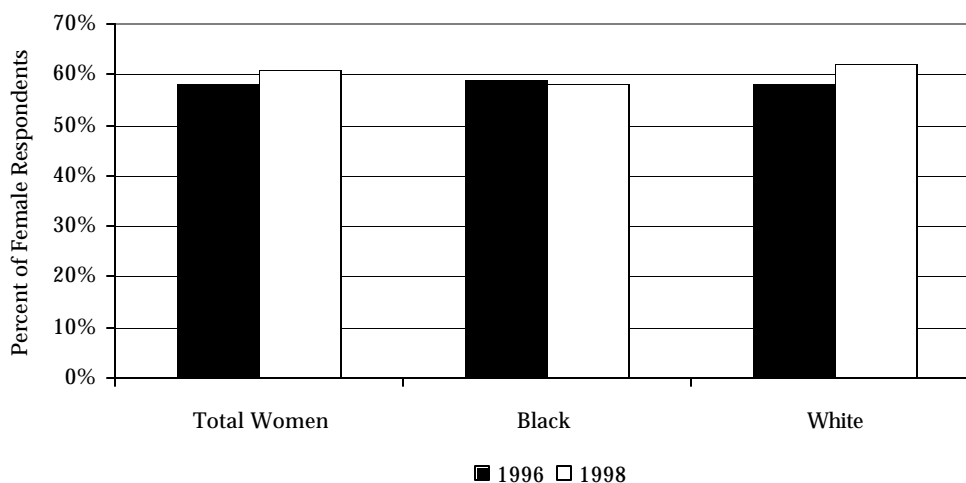
Mammography

Mammography rates in Nashville women were below the Healthy People 2010 targets in both 1996 and 1998; however women 45 years and older exceed the goal of 70% adherence (Figures 60 and 61). This finding is appropriate as it matches the recommendation that women age 40 and older have regular mammograms. No apparent racial disparities are seen between whites and blacks for mammography. Educational disparities are also negligible, although more respondents with less than a high school diploma reported having had a mammogram than respondents with higher levels of education (data not shown). There was only a small increase in reported mammograms from 1996 to 1998.

Data Sources

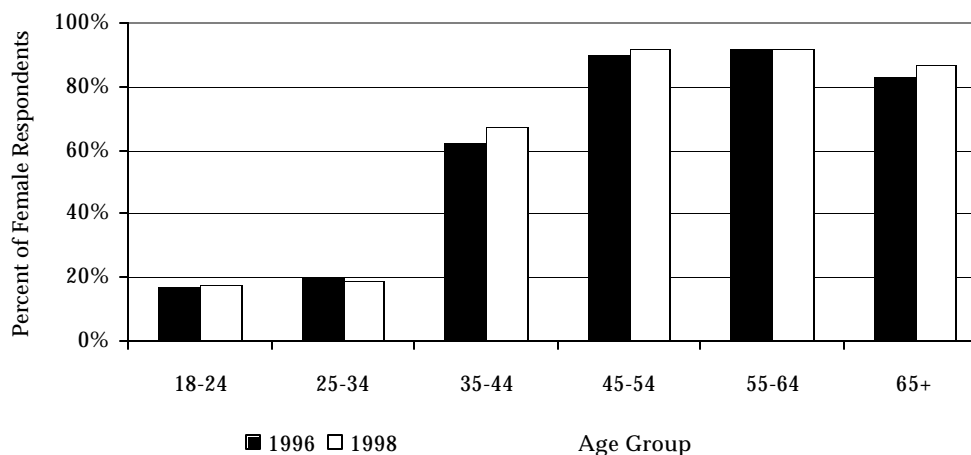
Metro Public Health
Department: BRFSS

Figure 60. Percent of Women Who Have Ever Had a Mammogram, Nashville, TN, BRFSS



Mammography rates in Nashville women were below the Healthy People 2010 targets in both 1996 and 1998; however, women 45 years and older exceed the goal of 70% adherence.

Figure 61. Percent of Women Who Have Ever Had a Mammogram by Age Group, Nashville, TN, BRFSS



Nashville rates are similar to those of Tennessee and the U.S. (Table 14). Data from the 2000 BRFSS for the U.S. and data specifically from Tennessee show similar trends with respect to the lack of racial disparity and higher rates in women with lower levels of education (data not shown).

Table 14. Age-adjusted Adherence Rates for Cancer Screening Tests

Test	Nashville, TN 1996	Nashville, TN 1998	Tennessee	U.S.
Mammography*	61%	63%	63%	62%
Pap test*	95%	95%	94%	95%
Digital Rectal Exam**	72%	76%^	64%	71%

* Tennessee and U.S. data are from the 2000 BRFSS.

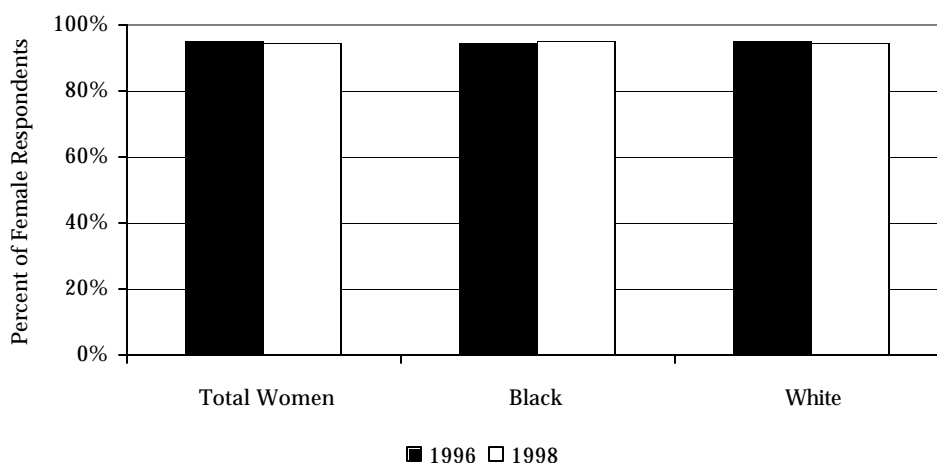
** Tennessee and U.S. data are from the 1995 BRFSS.

^ This rate is for men only; women were not asked the question regarding digital rectal exam in 1998.

Pap Tests

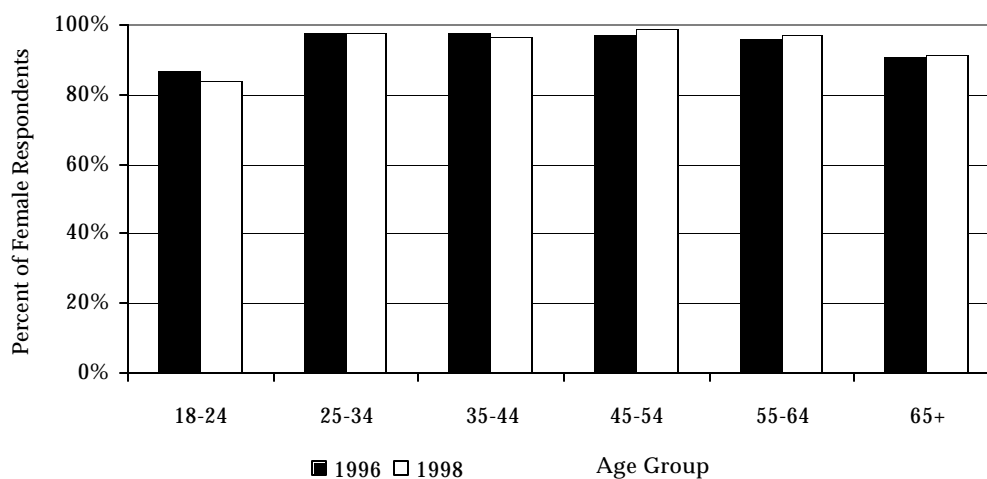
Nashville came very close to meeting the Healthy People 2010 targets for Pap tests. Adherence rates remained steady from 1996 to 1998 at 95% (Figure 62). When grouped by age, only the 18-24 age group was below the 97% national target (Figure 63). There was a slight trend towards better adherence with increasing education. No racial disparities were seen. The year 2000 BRFSS results showed that Tennessee and the U.S. had similar rates of adherence to the Pap test (Table 14).

Figure 62. Percent of Women Who Have Ever Had a Pap Test, Nashville, TN, BRFSS.



Nashville came very close to meeting the Healthy People 2010 targets for Pap tests.

Figure 63. Percent of Women Who Have Ever Had a Pap Test by Age Group, Nashville, TN, BRFSS.

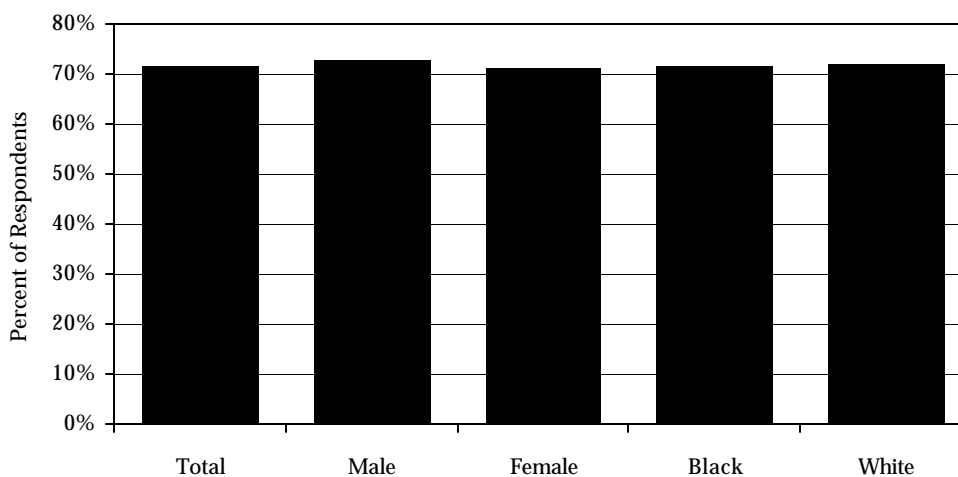


From the 1996 BRFSS, we estimated that 72% of adults over age 40 had a digital rectal examination.

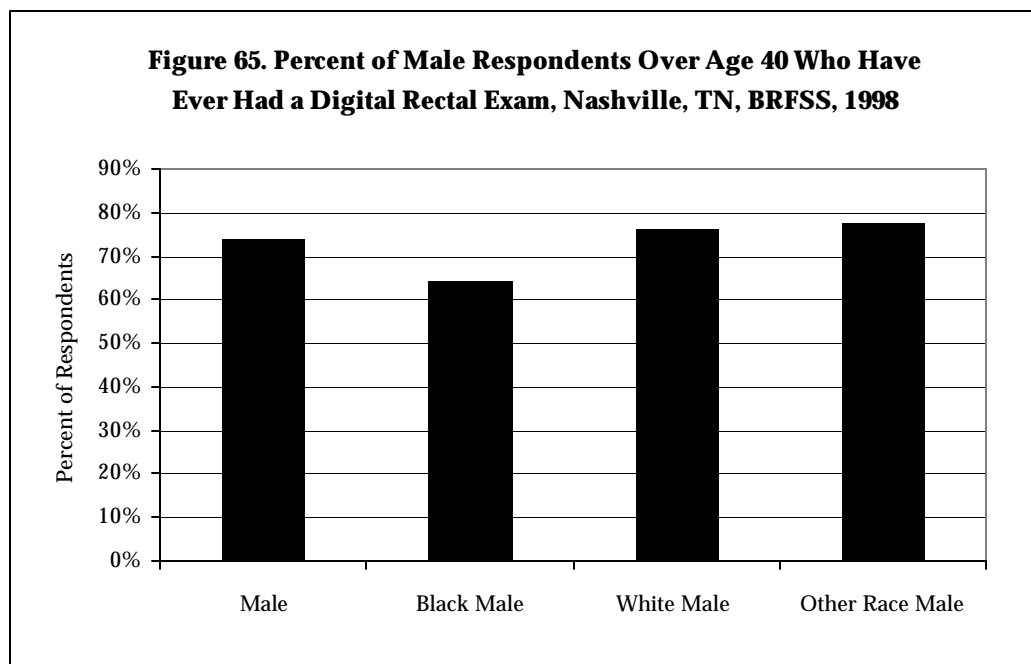
Rectal Exams

From the 1996 BRFSS, we estimated that 72% of adults over age 40 had a DRE (Figure 64). This estimate puts Nashville beyond the Healthy People 2000 target of 40%. In the 1998 survey, only men were questioned regarding DRE, and again the adherence was beyond the Healthy People 2000 target. Overall, there was no trend by respondent's education. There did appear to be better adherence in respondents over age 45. There was only a

Figure 64. Percent of Respondents Over Age 40 Who Have Ever Received a Digital Rectal Exam, Nashville, TN, BRFSS, 1996



small difference between black and white rates for DRE in 1996, but in 1998 when only men were surveyed, fewer blacks than whites reported having had the test – 64% compared to 76%, respectively (Figure 65).



After 1995, the national BRFSS questions regarding screening for colon cancer changed from DRE to sigmoidoscopy, to follow the change in screening recommendation. Data from the 1995 nationwide BRFSS show that the U.S. had similar DRE adherence rates compared to Nashville (Table 13). Tennessee's rates were slightly lower at 64%. The trend of increased adherence at older ages was also apparent in the nationwide data.

Discussion

Overall, Nashville residents' use of cancer screening tests are at or near the national goals. To keep the rates of screening tests at this level, the public health community must continue to promote awareness. The Tennessee Health Department's Breast and Cervical Cancer Early Detection Program is part of the CDC's national campaign to offer screening, education, and outreach to under-served women.⁴ The MPH Community Health Action Team works to promote breast cancer awareness and screening by offering breast self-exam education sessions. CDC and the U.S. Surgeon General have also initiated the Screen for Life Campaign to increase awareness about colorectal cancer and promote regular screening.⁵ Cancer screening tests are typically part of primary care, and should be obtained from a person's primary care physician. However, free tests are offered by some clinics and health care providers.

References:

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Overall, Nashville residents' use of cancer screening tests are at or near the national goals.

2.3 Health Care Systems

Adequacy of health care systems is an important determinant of health because it indicates the preparedness of hospitals and the medical community to deal with the growing demand for their services. In this report we will examine the health care systems in Nashville by looking at the number of hospital beds, hospital bed occupancy, emergency room visits, and the number of professional, licensed medical personnel.

Adequacy of health care systems is an important determinant of health.

Related Indicators

- Health care providers
- Lack of health insurance
- Health status and quality of life

2.3.1 Hospital Beds

Background

The number of hospital beds can be used as a measure of how prepared the community is to deal with the growing burden of chronic illness or outbreaks of communicable diseases. As the proportion of older adults in the population grows, so does the prevalence of chronic diseases. Some chronic diseases such as congestive heart failure result in more frequent hospitalizations, thus increasing the rate of hospital admissions and the demand for hospital beds.¹ As communities increase their preparedness for possible bioterrorism attacks, more attention is being given to the number of hospital beds available to care for large numbers of victims that need medical care simultaneously.

The number of hospital beds in the U.S. has been steadily shrinking since the mid 1980s.² Some researchers attribute this trend to a reduction in government subsidies and regulations for hospitals and the need for hospitals to save money.³ Fewer hospital beds can leave a community poorly prepared for higher admission rates and greater demand for Emergency Room (ER) care. This is exactly what is happening in the U.S. today. The American Hospital Association reports that hospital admissions have risen approximately 7% from 1994 to 2000.⁴ There are many explanations for the increased admissions, including recent changes in health insurance that allow more patients to stay overnight at the hospital and the fast growing numbers of older adults in the population.

The Tennessee Department of Health oversees the Joint Annual Survey of Hospitals. The survey contains information from all licensed hospitals in the state and includes the number of licensed and staffed beds, average daily census, and number of emergency room visits for the preceding year.⁵ The last year for which data is available is 2000. Using this information for Nashville hospitals, we considered Nashville's hospital bed availability and how it compares to Tennessee and the U.S.

Findings

Hospital Beds

There were 4,137 licensed and 3,424 staffed hospital beds in general medical and surgical hospitals in Nashville in the year 2000 (Table 15). The number of licensed beds per 1,000 population increased from 6.9 in 1999 to 7.3 in 2000. The number of staffed beds per 1,000 population also grew from 5.8 in 1999 to 6.0 in 2000. Figure 66 shows that Nashville has more licensed and staffed hospital beds per population than the other three metropolitan/urban counties in Tennessee (Shelby, Knox, and Hamilton). Nashville also has more beds per population than Tennessee (3.8 staffed beds per 1,000 population in 2000) and the U.S. (3.0 beds per 1,000 population in 2000⁴). Nashville is primarily an urban community, while Tennessee and the U.S. encompass both urban and rural areas.

Hospital Occupancy

The average daily census (or filled hospital beds) for Nashville hospitals was 2,455 in 2000. This was an 18% increase from 2,079 filled beds in 1999. Hospital occupancy (or filled beds per staffed beds) in Nashville was 72% in 2000, up from 69% in 1999. There has been a steady increase in hospital occupancy in Nashville over the last six years. There was a 19% increase from the 1995 rate (60%) to the 2000 rate (72%). In 2000, Nashville hospitals had higher occupancy than Knox and Hamilton Counties (Table 15), but lower occupancy

Data Sources

Tennessee Department of Health

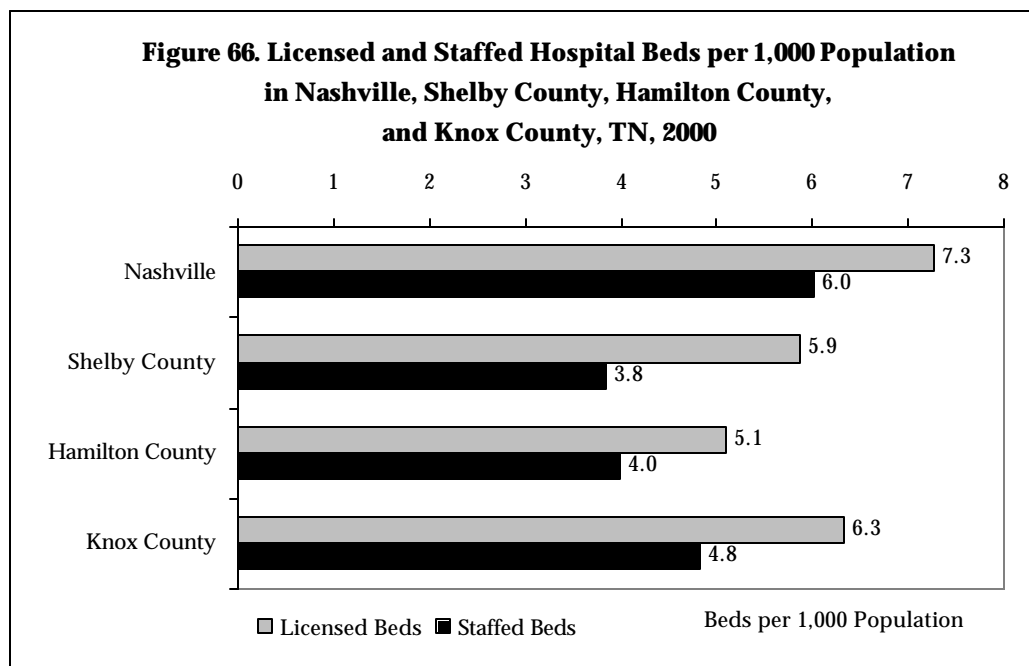
Table 15. Hospital Beds, Average Daily Census, and Occupancy in Nashville, Shelby County, Hamilton County, Knox County, and Tennessee, 1999 and 2000

Location	1999				2000			
	Licensed Beds	Staffed Beds	Average Daily Census	Hospital Occupancy*	Licensed Beds	Staffed Beds	Average Daily Census	Hospital Occupancy*
Nashville	3,631	3,067	2,079	69%	4,137	3,424	2,455	72%
Shelby County	4,982	3,277	2,349	72%	5,264	3,446	2,693	78%
Hamilton County	1,589	1,226	697	61%	1,570	1,225	725	59%
Knox County	2,420	1,765	1,124	64%	2,420	1,840	1,198	65%
Tennessee	23,388	17,931	10,240	58%	21,401	16,283	10,508	65%

*Hospital Occupancy is calculated from average daily census divided by the number of staffed beds.

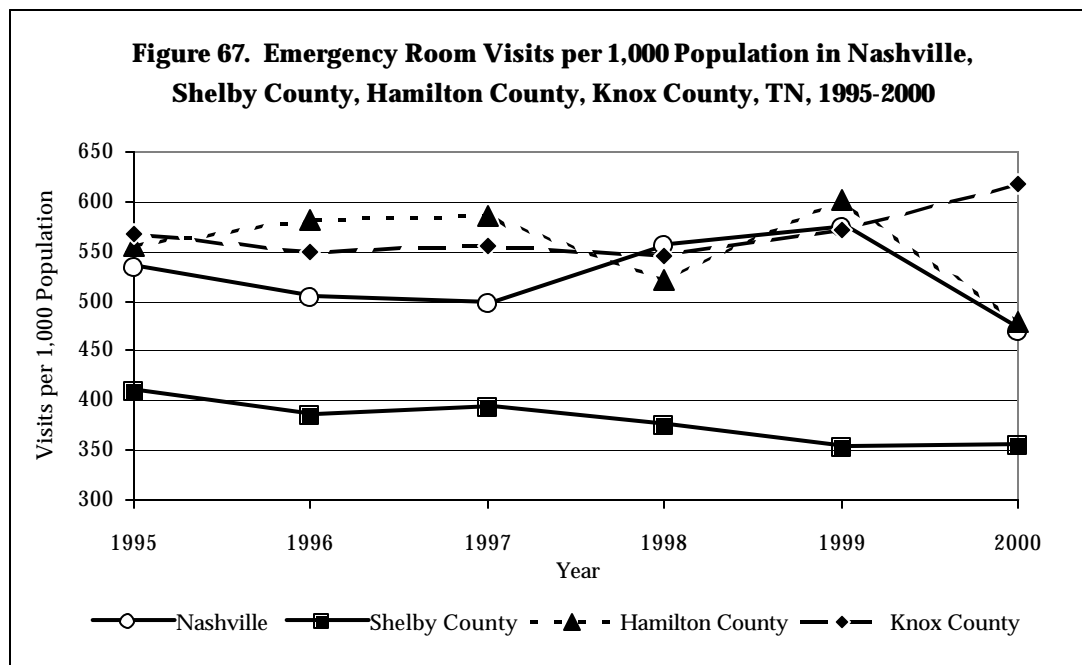
Data Source: Tennessee Department of Health.

than Shelby County hospitals. Nashville's occupancy rate was also higher than the Tennessee rate (65%) in 2000 and the U.S. rate (64%).



Emergency Room Visits

There were 267,274 emergency room visits in Nashville in 2000. The rate of visits per 1,000 population was 469, an 18% decrease from the 1999 rate of 573 per 1,000 population. Nashville's six-year trend (Figure 67) shows a decline in ER visits from 1995 to 1997, then an increase from 1997 to 1999. However, in 2000 we resumed a declining trend as the rate fell to a six-year low. The Hamilton County ER visit rate



(480 per 1,000 population) was approximately the same as Nashville's in 2000. The Knox County ER visit rate (617 per 1,000 population) was higher than Nashville's rate. Shelby County had much fewer ER visits per population (354 per 1,000 population) than Nashville in 2000.

Discussion

Nashville appears to be on its way to being prepared for higher numbers of hospital admissions. Nashville hospitals are staffing more beds, but with rising occupancy rates, even more beds may be necessary. Historically, hospitals have considered 85% occupancy to be optimal for providing adequate care to patients and producing sufficient revenue.³ But, this may not be true in all cases. The number of beds, staff, average length of stay, and influx of emergency and urgent patients all must be considered to decide what maximum occupancy is possible. One study showed that occupancy of 85% or higher might result in a delay of bed-assignment for as much as 15% of emergency patients.³ If patients can not be placed in an inpatient bed, they may remain in the ER longer and contribute to ER overcrowding. Insufficient hospital beds and ER overcrowding put the public at higher risk for poor medical outcomes due to delay in treatment, prolonged pain and suffering, and perhaps even avoidance of care.⁶ Therefore, it is in the best interest of public health for Nashville hospitals to maintain their current numbers of staffed beds and to increase them as necessary.

There were 4,137 licensed and 3,424 staffed hospital beds in general medical and surgical hospitals in Nashville in the year 2000.

References:

1. Kozak, LJ, Hall, MJ, Owings, MF. Trends in avoidable hospitalizations, 1980-1998. *Health Affairs*. 2001;20(2):225-32.
2. Halpin Schauffler H, McMenamin S, Zawacki H. *Health Care Trends and Indicators in California and the United States*. Menlo Park, California: The Kaiser Family Foundation; June 2000.
3. Green LV, V Nguyen. Strategies for cutting hospital beds: the impact on patient service. *Health Services Research*. 2001;36(2):421-42.
4. Health Forum, an affiliate of American Hospital Association. *2000 AHA Annual Survey*. Chicago, IL: Health Forum; 2002.
5. Tennessee Department of Health. Description of Joint Annual Report of Hospital Data [online]. Available at: <http://hitspot.utk.edu/~chrghospdesc.htm>. Accessed May 23, 2002.
6. Derlet RW, JK Richards. Overcrowding in the nation's emergency departments: complex causes and disturbing effects. *Annals of Emergency Medicine*. 2000;35(1):63-68.

The number of hospital beds can be used as a measure of how prepared the community is to deal with the growing burden of chronic illness or outbreaks of communicable diseases. As the proportion of older adults in the population grows, so does the prevalence of chronic diseases. As communities increase their preparedness for possible bioterrorism attacks, more attention is being given to the number of hospital beds available to care for large numbers of victims that need medical care simultaneously.

Related Indicators

- Hospital beds
- Lack of health insurance
- Health status and quality of life

2.3.2 Health Care Providers

Background

In addition to hospital beds, the number of licensed health care providers is also an important indicator of the readiness of our community to deal with both existing health care needs and new ones in the future. The number of medical professionals might also influence the trends in access to care for under-served populations in our community.¹ Despite the importance of ensuring that there are adequate medical professionals in a community, there are no absolute guidelines for determining the target numbers. The U.S. Health Resources and Services Administration, as well as other federal and non-federal organizations, have created estimates of the optimal physician per population ratios. These estimates provide some guidance, but could easily be misleading if any of several influencing factors change – the age composition of the population, the number of persons with health insurance, increased use of medical services by minorities, or changes in physicians' productivity. Also, the current national shortage of nurses and shortage of primary care physicians could diminish the pool of providers from which Nashville has to draw.

For this report, we obtained the numbers of licensed medical professionals (nurses, physicians, and physician assistants) in Nashville for 2001 from the Tennessee Department of Health. The most recent year for which state-wide and nation-wide data available is 1999.

Findings

Physicians

There were 2,789 licensed medical doctors (MDs) and doctors of osteopathy (DOs) in Nashville in 2001. The physician to population ratio was 1 to 204, or 4.9 licensed physicians per 1,000 population. Nashville has a more favorable physician-to-population ratio than both Tennessee and the U.S. – in 1999, the U.S. ratio was 1 to 355 and the ratio in Tennessee was 1 to 437.

Physicians in the fields of internal medicine, family practice, and general practice typically provide primary care services. Nashville had 677 primary care physicians in 2001, with a physician to population ratio of 1 to 842. Nashville also had 106 licensed emergency medicine physicians in 2001, for a physician to population ratio of 1 to 5,377 or 19 per 1,000 population. (Table 16.)

Nurses and Physician Assistants

There were 2,499 licensed practical nurses (LPNs), 10,277 registered nurses (RNs) including nurse practitioners, and 84 physician assistants (PAs) in Nashville in 2001, for a total of 12,860 mid-level medical care providers. There were 4.6 nurses or PAs for each doctor in Nashville and one nurse or PA for every 44 county residents.

Data Sources

Tennessee Department of Health

Table 16. Licensed Health Care Providers in Nashville 2001, Tennessee 1999, and U.S., 1999

Profession	Nashville, 2001			Tennessee, 1999			U.S., 1999		
	Number	Provider to Population Ratio	Providers per 1,000 Population	Number	Provider to Population Ratio	Providers per 1,000 Population	Number	Provider to Population Ratio	Providers per 1,000 Population
Licensed Practical Nurses (LPN)	2,499			21,980			^		
Registered Nurses (RN)*	10,277			52,505			^		
LPN and RN	12,776	44.6	22.4	74,485	73.6	13.6	2,205,440	123.7	8.1
Physician Assistants (PA)	84			^			^		
LPN, RN, PA	12,860	44.3	22.6	^			^		
Doctors of Osteopathy (DO)	18			^			^		
Medical Doctors (MD)	2,771			^			^		
MD and OD	2,789	204.4	4.9	12,550	437.0	2.3	767,592	355.0	2.8
MD - Emergency Medicine	106	5377.2	0.2	^			^		
MD - Internal Medicine (IM)	540			^			^		
MD - Family Practice (FP)	101		0.2	^			^		
MD - General Practice (GP)	36		0.1	^			^		
MD - IM, FP, GP	677	841.9	1.2	^			^		

*Registered nurses includes nurse practitioners.

^ Data not available.

Discussion

Nashville is fortunate to have a large number of health care providers to serve its population; however, we cannot expect that this trend will continue. The shortage of nurses continues to be a nation-wide crisis that is getting attention on the federal level. The U.S. House of Representatives is considering the Nursing Employment and Educational Development Act to address nurse recruitment and offer incentives to nurses.³ In January 2002, California passed a law to mandate the nurse to patient ratio, and became the first state to legally address the nursing crisis and its implication for quality of care. Primary care physician shortages are also a growing problem. A study using the recently revised version of the physician supply trend model found that by the year 2020, the U.S. will have a deficit of 200,000 physicians.⁴ Perhaps, because Nashville has two local medical schools, we may not be as harshly impacted by the coming physician shortage, but the public health community must be mindful of the potential for it to occur.

References:

1. Greenberg L, JM Cultice. Forecasting the need for physicians in the United States: the Health Resources and Services Administration's physician requirements model. *Health Services Research*. 1997;31(6):723-37.
2. Kaiser Family Foundation. State Health Facts Online [online]. Available at: <http://stathealthfacts.kff.org>. Accessed May 9, 2002.
3. H.R. 3020. Nursing Employment and Education Development Act [online]. Available at: <http://thomas.loc.gov/cgi-bin/query/C?c107:/temp/~c1079hrQlt>. Accessed May 23, 2002.
4. Cooper RA, Getzen TE, McKee HJ, Laud P. Economic and demographic trends signal an impending physician shortage. *Health Affairs*. 2002;21(1):140-54.

Nashville is fortunate to have a large number of health care providers to serve its population. There were 2,789 licensed medical doctors (MDs) and doctors of osteopathy (DOs) in Nashville in 2001. Nashville had a more favorable physician-to-population ratio than both Tennessee and the U.S. In 1999, the U.S. ratio was 1 to 355 and the ratio in Tennessee was 1 to 437.

Chapter Three

Health Status

Health status

The health status of Nashville is a description of the health of the total population, using information representative of most people living in this city. For relatively small population groups; however, it may not be possible to draw accurate conclusions about their health using current data collection methods.

It is generally accepted that there are two components to health status, (1) a subjective one based on an individual, personal reading of health status, and (2) a so-called objective one based on a normative, professional assessment. Subjective health status is defined as a person's own assessment of his or her health. Objective health status refers to an assessment by a health professional. It is recognized that a professional assessment remains a judgment, though based on criteria that are more specific and on which some consensus has been reached.¹

The information used to report health status comes from a variety of sources, including birth and death records, disease information collected by the Metropolitan Public Health Department of Nashville and Davidson County, and telephone surveys regarding individual risk behaviors.

Reference:

1. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.

Two components of health status are:

1. Subjective health status
2. Objective health status

Related Indicators

- Educational attainment
- Employment/
Unemployment
- Poverty level
- Household income

Additional Data

Appendices
pages D-43 - D-44

Data Sources

Metro Public Health
Department: BRFSS

3.1 Health Status and Quality of Life

Background

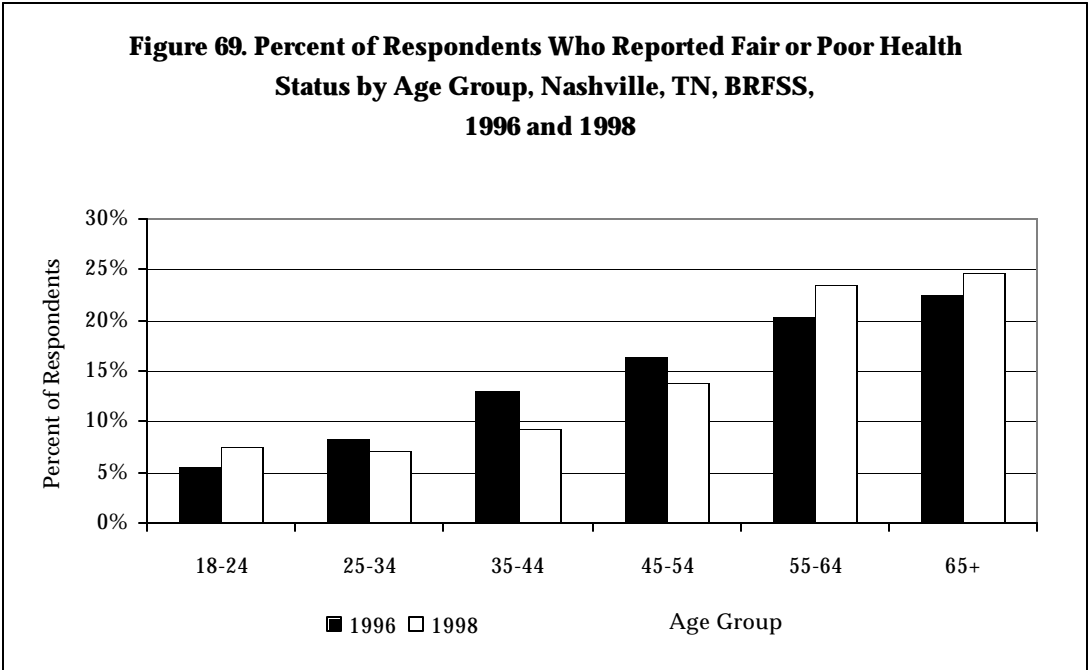
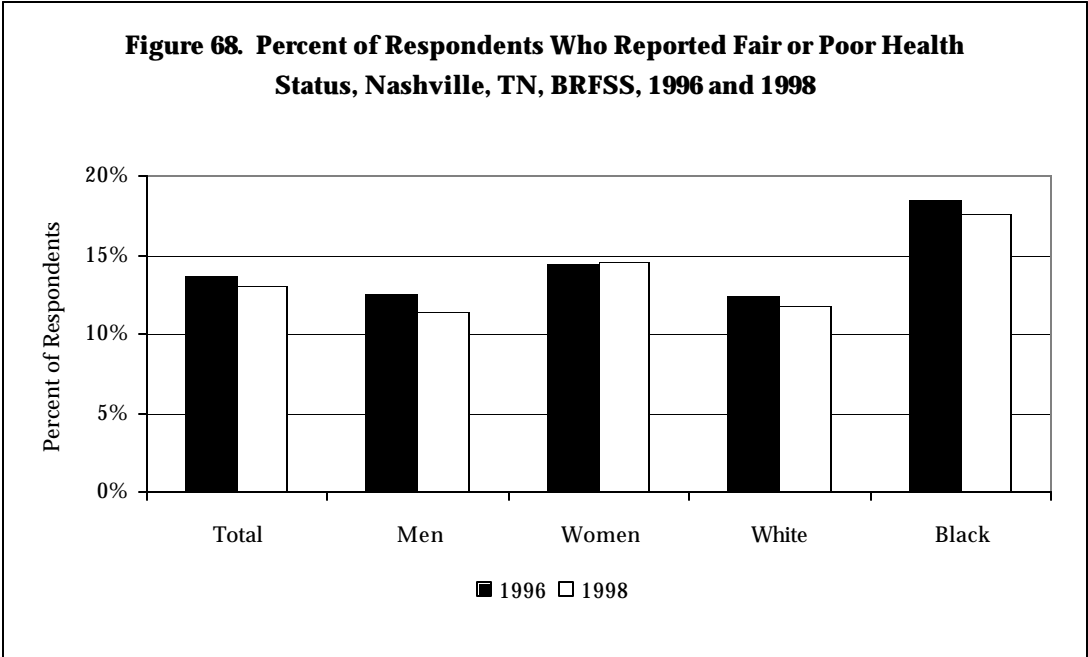
Self-reported quality of life and health status indicators are valuable in assessing the overall health status of a community. They allow the public health community to assess the byproducts of morbidity that are not typically observed in disease surveillance. The World Health Organization first defined quality of life in 1947 to capture the concept of health with optimal physical, mental, and social functioning.¹ Unlike other health status measures, quality of life also captures information about how a person's health perceptions might influence their estimation of their own health status.¹ Health-related quality of life (HRQOL) is often measured in certain subgroups that are considered to be at high risk for disability, such as the elderly or persons with disabling chronic conditions. Measuring HRQOL in the general population offers a basis for the public health community to project demand on services, resources allocation, and even evaluation of existing intervention efforts.²

Nashville's 1996 and 1998 BRFSS contain the questions we used to estimate health status and quality of life for Nashville residents. The health status question asked respondents to rate their health as excellent, very good, good, fair, or poor. To reduce the number of categories, we grouped responses as "good or better" and "fair or poor". Quality of life was broken into two categories based on the questions asked in the BRFSS. The first category, unhealthy days, is calculated as the mean number of days that respondents had poor mental or physical health in the last 30 days. The second category, activity limitation days, is calculated as the mean number of days that respondents were limited in their usual daily activities due to poor mental or physical health.

Findings

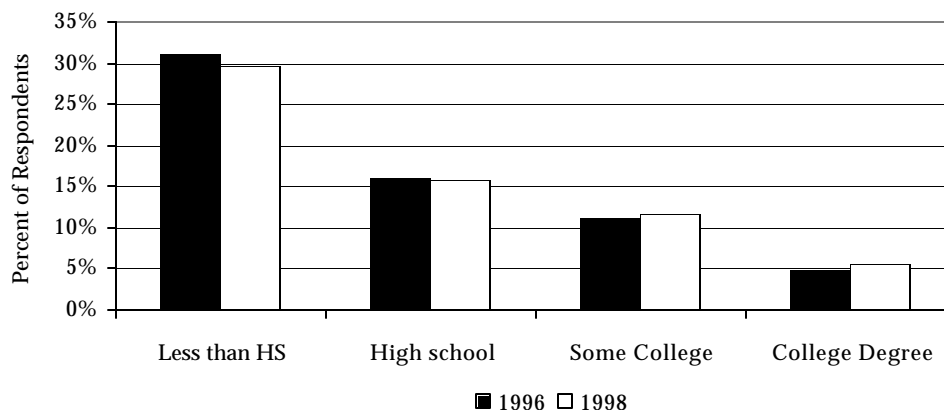
Health Status

Approximately 14% of respondents reported fair or poor health status in 1996 (Figure 68). More black respondents rated their health as fair or poor than whites. The overall gender and racial group proportions did not change very much in 1998. When grouped by age, the percentage of persons with self-rated fair or poor health was highest in the 65 and older age group for both survey years (Figure 69). Between 1996 and 1998, the percentage of respondents in fair or poor health increased for the 18-24, 55-64, and 65+ age groups, but it decreased in the middle-age groups of 25-34, 35-44, and 45-54. Respondents with education less than a high school diploma had the highest percentage who rated their health fair or poor – 31% in 1996 and 30% in 1998 (Figure 70). There was little change in the percentages by education level from 1996 to 1998.



Approximately 14% of respondents reported fair or poor health status in 1996 and 1998.

Figure 70. Percent of Respondents Who Reported Fair or Poor Health Status by Education Level, Nashville, TN, BRFSS, 1996 and 1998



Unhealthy Days

Respondents had an average of 5.7 days when their physical or mental health was not good (unhealthy days) in the 30 days prior to their interview (Table 17). Women had a higher average of unhealthy days than men (6.4 compared to 4.9). There was no apparent difference between black and white groups. The 25-34 years age group had the fewest unhealthy days (3.9), while the 55-64 group had the most (7.1). Respondents with more education reported less unhealthy days.

The overall trend was fewer reported unhealthy days in all groups in 1998. Total respondents in 1998 reported 5.2 unhealthy days. In 1998, there was a difference between black and white groups – blacks reported more unhealthy days than whites (5.6 compared to 5.1). Trends for gender and education were the same as in 1996. The age group with the least number of unhealthy days changed from the 25-34 group to the 65 years and older group in 1998.

The overall trend was fewer reported unhealthy days in all groups in 1998.

Table 17. Mean Number of Unhealthy Days and Activity Limitation Days in Adult Respondents to the Nashville BRFSS, 1996 and 1998

	Mean Unhealthy Days		Mean Activity Limitation Days	
	1996	1998	1996	1998
Total	5.7	5.2	1.7	1.7
<i>Sex</i>				
Male	4.9	4.4	1.6	1.5
Female	6.4	5.9	1.8	1.8
<i>Race</i>				
White	5.7	5.1	1.7	1.7
Black	5.7	5.6	1.9	1.5
<i>Age Groups (years)</i>				
18-24	5.6	5.3	1.4	1.1
25-34	3.9	5.0	1.0	1.5
35-44	5.8	5.1	1.8	1.6
45-54	6.5	5.4	2.2	2.0
55-64	7.1	5.9	3.0	2.3
65+	4.8	3.4	1.1	1.3
<i>Education Completed</i>				
Less than High School	7.8	7.1	2.7	2.5
High School	6.3	5.9	1.8	2.0
Some College	5.7	4.9	1.8	1.4
College	3.5	3.7	0.8	1.1

Activity Limitation Days

In 1998, the overall average of activity limitation days (1.7) was the same as in 1996.

As a result of poor physical or mental health, respondents to the 1996 survey reported their usual activities were limited an average of 1.7 days in the 30 days prior to their interview (Table 17). Women had a slightly higher average of activity limitation days than men, and blacks reported more activity limitation days than whites. When the 1996 respondents were grouped by age, the 25-34 years age group reported the fewest days (1.0) of activity limitation and the 55-64 years group reported the most (3.0). Respondents with less than a high school diploma had the highest average for activity limitation days than any education group (2.7).

In 1998, the overall average of activity limitation days was the same as in 1996, but there were many changes in the population groupings. Blacks reported fewer average days than whites (1.5 compared to 1.7). The average number of activity limitation days increased in the 25-34 years age group leaving the 65 years and older group as the one with fewest days, even though this age group also had an increase in average days from 1996 to 1998. All other age groups had a decrease in average activity limitation days. The general trend for education level was still fewer days in higher education level groups. However, the average number of days rose for the high school and college degree groups while it declined for the groups with less than a high school diploma and only some college.

Comparison to Tennessee and United States

Nashville had a smaller proportion of BRFSS respondents in the fair or poor health category than Tennessee, and about the same proportion as the U.S. (Table 18). When considering gender and race, again the proportion of Nashville respondents was similar to that of the U.S. and smaller than that of Tennessee. The difference in the races was opposite for Tennessee and Nashville – more whites in Tennessee reported fair or poor health, but in Nashville blacks had the higher proportion.

Overall, Nashville residents consider themselves to be in fairly good health.

The distribution of days of poor physical and mental health was approximately the same in Nashville, Tennessee, and the U.S. (data not shown). From the Nashville 1998 BRFSS, it appears that Nashville women reported fewer poor physical health days than women in Tennessee or the U.S. Also from the 1998 survey, Nashville respondents may have had more poor mental health days than Tennessee or the U.S.

Table 18. Age-adjusted* Percentages of Respondents with Self-rated Health Status of Fair or Poor, Nashville 1996 and 1998, Tennessee 1999, and U.S. 1999

	Nashville BRFSS 1996	Nashville BRFSS 1998	Tennessee BRFSS 1999	U.S. BRFSS 1999**
Total	14%	14%	20%	13%
Male	14%	12%	19%	13%
Female	15%	15%	20%	14%
White	13%	12%	21%	12%
Black	21%	20%	18%	17%

* Age-adjusted to the U.S. 2000 standard population.

** U.S. BRFSS data reflects the median values from data collected for the 50 states, District of Columbia, and Puerto Rico.

Discussion

Overall, Nashville residents consider themselves to be in fairly good health. Health status and quality of life measures should reflect the public health community's efforts to promote good health, therefore, these results suggest that we are doing a fairly good job. However, there is always room for improvement. As we further address and work to solve the racial disparities in morbidity and mortality in Nashville, we hope to see our work reflected in these general yet multidimensional measures. It will not be specific interventions that make the difference in improving quality of life, but the spectrum of public health prevention and promotion activities that will improve the health status of our community as a whole.

References:

1. Hennessy CH, Moriarty DG, Zack MM, et al. Measuring health-related quality of life for public health surveillance. *Public Health Reports*. 1994;109(5):665-72.
2. Simon P, Lightsone A, Zeng Z, et al. Health-related quality of life-Los Angeles County, California, 1999. *Morbidity and Mortality Weekly Report*. 2001;50(26):556-9.

3.2 Maternal and Infant Health

The health of women and children is a very important part of our community's health. Birth, infancy, childhood, adolescence, sexual maturity, and childbearing are events in the life cycle that come with physical and social health risks for women, children, and adolescents.

In Nashville, females constituted 51.6% of the year 2000 population; children aged 0-19 constituted 25.4% of the year 2000 population. Together, females and children aged 0-19 constituted 64.6% of Nashville's 2000 population. In the year 2000, 8,946 babies were born to females aged 15-44 in Nashville, and there were 139,540 females aged 15-44 in Nashville in 2000.

Together, females and children aged 0 - 19 constituted 64.6% of Nashville's 2000 population. In the year 2000, 8,946 babies were born to females aged 15 - 44 in Nashville, and there were 139,540 females aged 15 - 44 in Nashville.

Related Indicators

- Sexual behavior
- Prenatal care
- Perinatal and infant mortality
- Low birth weight
- Preterm birth

Additional Data

Appendices
pages D-45 - D-46

Data Sources

- Metro Public Health Department
- Tennessee Department of Health

3.2.1 Teen Births

Background

Teenage pregnancy is a problematic and complex issue for any community. There are often adverse economic, social, and health consequences for both the adolescent mother and her child. Teenage mothers are less likely than other teenage females to finish high school or maintain steady employment.¹ These young mothers are also less likely than older women to receive early and adequate prenatal care, and more likely than older women to experience complications during pregnancy such as inadequate weight gain, anemia, preterm labor, and pregnancy-induced hypertension.^{1,2}

Infants born of teenage mothers are at risk for adverse health consequences as well. These infants have a greater risk of low birth weight, infant mortality, and other complications of delivery such as respiratory distress syndrome and anemia.^{1,2}

The following sections present the data for teen births in Nashville, Tennessee. Several indicators have been developed to measure teen births. The standard indicator is Births to Females Aged 15 - 19. Alternates are 1) Births to Females Aged 10 - 17; 2) Births to Females Aged 10 - 14; 3) Births to Females Aged 10 - 19; and 4) Repeated Births to Teenagers 10 - 19.

Births to Females Aged 15 - 19 includes almost all births to teenagers. Births to Females Aged 10 - 17 tracks teenagers of school age for school health and family planning programs. Births to Females Aged 10 - 14 is a sentinel indicator to track births to very young females. Births to Females Aged 10 - 19 tracks all births to teenagers under 20. Repeated Births to Females Aged 10 - 19 helps to determine the effectiveness of family planning efforts in preventing teenagers who have borne a child from giving birth to a second child while still in their teens.

Findings

Births to Females Aged 15-19

In the year 2000, there were approximately 59 babies born for every 1,000 females aged 15-19 in Nashville (Figure 71). There is a large difference between the number of births to white females aged 15-19 compared to black females of the same age for the year 2000. For white females, there were approximately 52 babies born per 1,000, compared to approximately 80 babies per 1,000 born to black females of the same age group. Those of other races experienced the lowest birth rate, with approximately 19 babies born per 1,000 females aged 15-19.

Comparing Nashville's data to Tennessee and with that of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, yields some important observations (Figure 72). All rates discussed are per 1,000 females aged 15-19. The birth rates for teenagers aged 15-19 in Nashville are similar to those in Hamilton County, and Tennessee; 59.2 for Nashville compared with 58.2 for Hamilton, and 59.2 for Tennessee overall. Knox County, however, has a teen birth rate (38.8) much lower than all other geographical areas included in the comparison. On the other side of the spectrum, the rate for Shelby County (72.0) exceeds the rate for all other counties, as well as Tennessee.

Figure 71. Birth Rates Among Females Aged 15-19 by Race, Nashville, TN, 2000

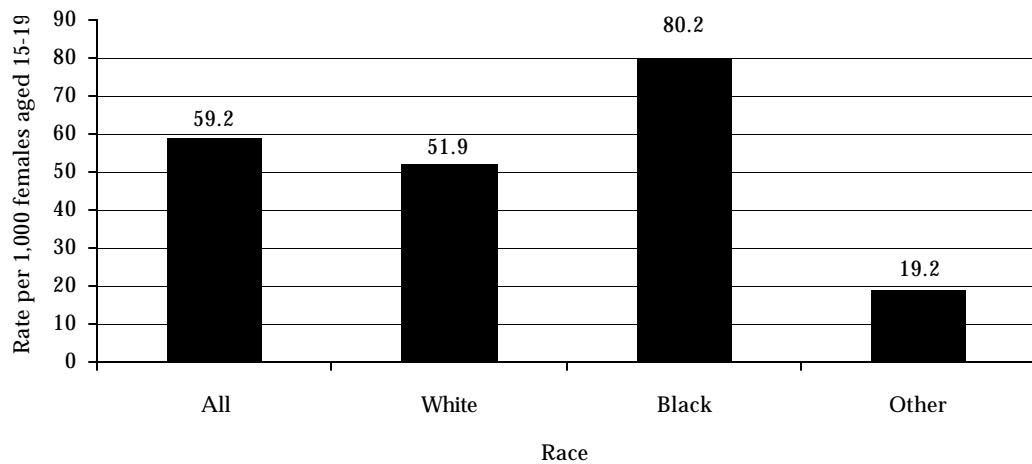
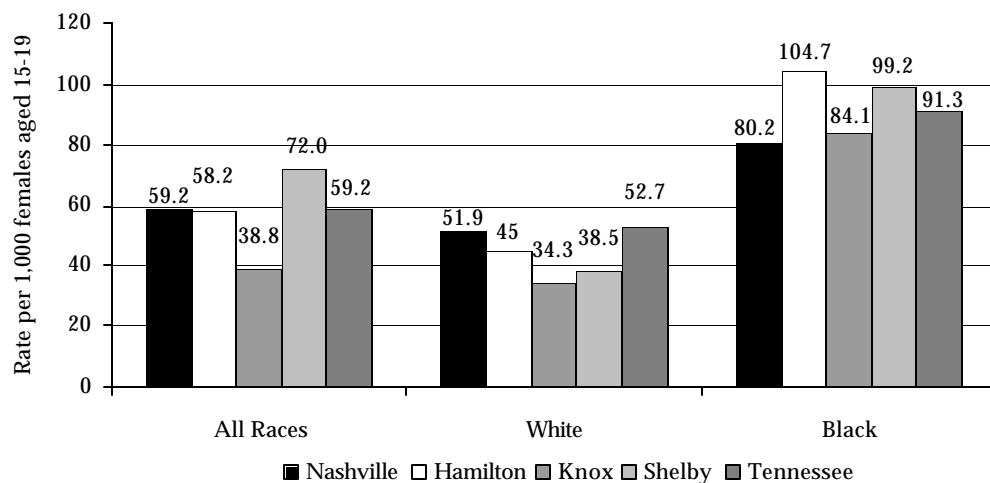
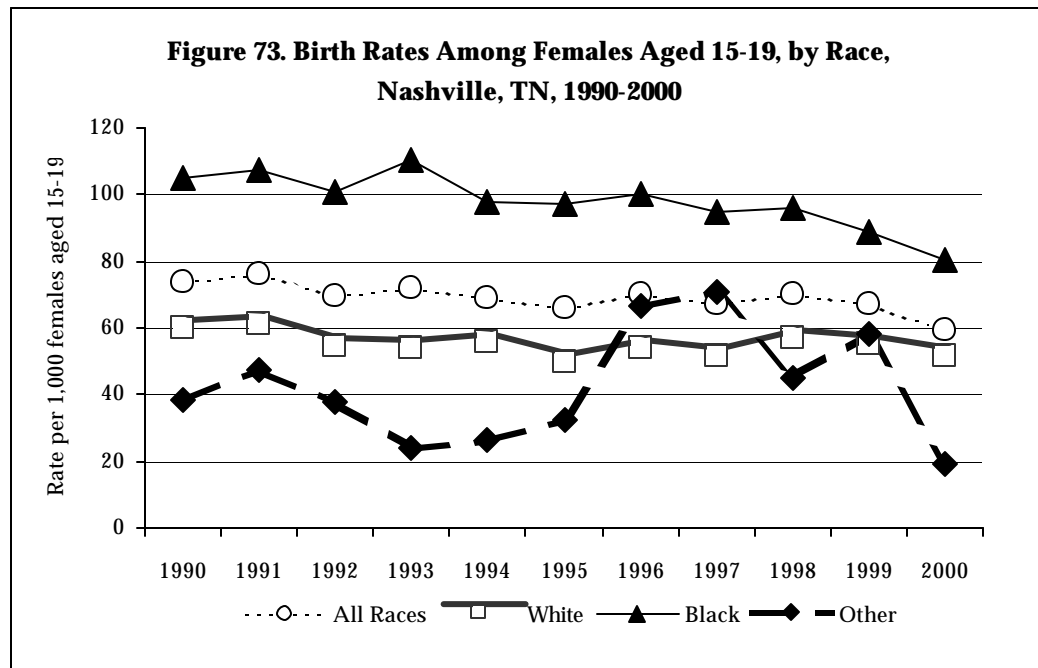


Figure 72. Birth Rates Per 1,000 Females Aged 15-19, by Race for Selected Counties in Tennessee, 2000



Examining the differences in teen birth rates by race, it is apparent that the disparity between whites and blacks exists in each county under examination, as well as for the state as a whole. Each county, as well as the state, has a lower rate of white teen births than black teen births. Further examination reveals that Nashville has the highest rate of white teen births (51.9) excluding the State (52.7), while Hamilton County has the highest rate of black teen births (104.7). Knox County has the lowest rate of white teen births in this age group (34.3), and Nashville has the lowest rate of black teen births (80.2).

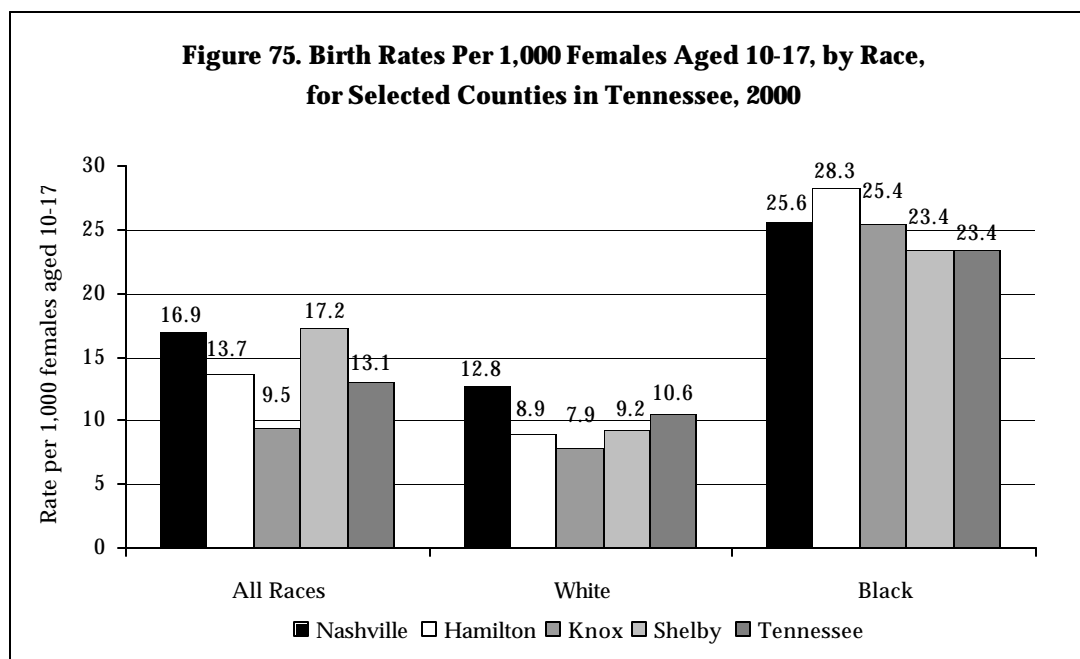
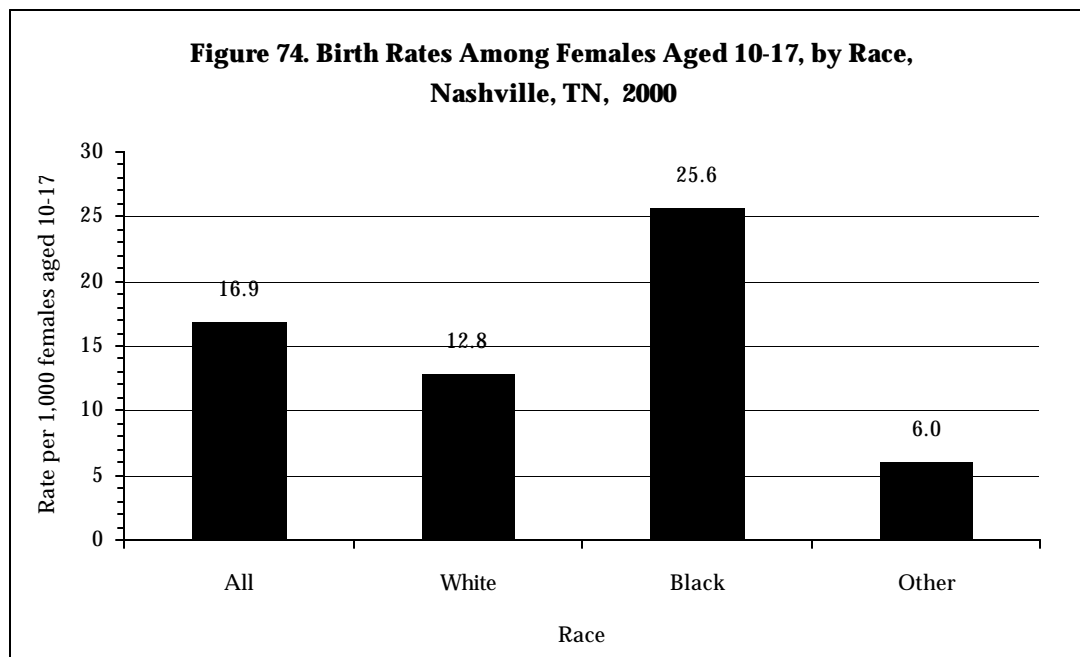
On a national level, teenage births have been declining since the late 1950's,³ reaching a low of 48.5 births per 1,000 females aged 15-19 in the year 2000.⁴ A similar declining trend can be noted for teenage births aged 15-19 in Nashville. As illustrated in Figure 73, there were 74 babies born per 1,000 females aged 15-19 in 1990. This rate has declined to 59.2 in the year 2000, a decrease of 20%. This declining trend is still in evidence when examining birth rates by race. For whites, the rate was 59.8 per 1,000 in 1990 and had declined to 51.9 per 1,000 in the year 2000, a decrease of 13%. The rate for blacks was 104.8 per 1,000 in 1990 and had dropped to 80.2 per 1,000 in 2000, a decrease of 23%; those of other races experienced a rate of 38.6 per 1,000 in 1990 and a much lower rate of 19.2 in 2000, a decrease of 50%. The apparent fluctuation in the birth rate for females of other races is most likely due to the small number effect, where small numbers produce unstable rate estimates. (See Technical Notes.)



Births to Females Aged 10-17

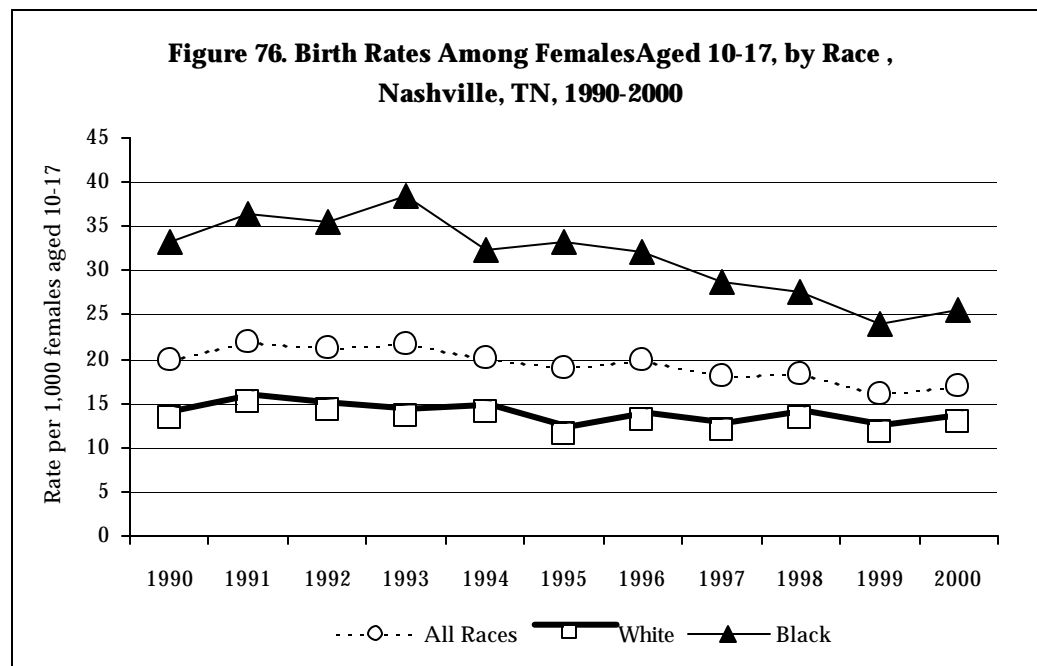
In the year 2000, there were approximately 17 babies born for every 1,000 females aged 10-17 in Nashville (Figure 74). There is a large difference between the number of births to white females aged 10-17 compared to black females of the same age for the year 2000. For white females, there were approximately 13 babies born per 1,000, compared to approximately 26 babies per 1,000 born to black females of the same age group. Those of other races experienced the lowest birth rate with approximately 6 babies born per 1,000 females aged 10-17.

Comparing Nashville's data with that of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, and Tennessee, yields observations similar to those noted for teen births to females aged 15-19 (Figure 75). All rates discussed below are per 1,000 females aged 10-17. The birth rates for teenagers aged 10-17 in Nashville (16.9) is second only to the rate of Shelby County (17.2). Nashville exceeds both the rate of Tennessee (13.1) and the rate of Hamilton County (13.7). Knox County has the lowest rate of those compared with 9.5 births per 1,000 women aged 10-17.



There is a large disparity between the rates for whites and blacks in the geographic areas under consideration. Each county, as well as Tennessee, has a lower rate of white teen births than black teen births in this age group. Further examination reveals that Nashville has the highest rate of white teen births (12.8), while Hamilton County has the highest rate of black teen births (28.3). Knox County has the lowest rate of white teen births in this age group (7.9), and Shelby County ties with Tennessee for the lowest rate of black teen births (23.4).

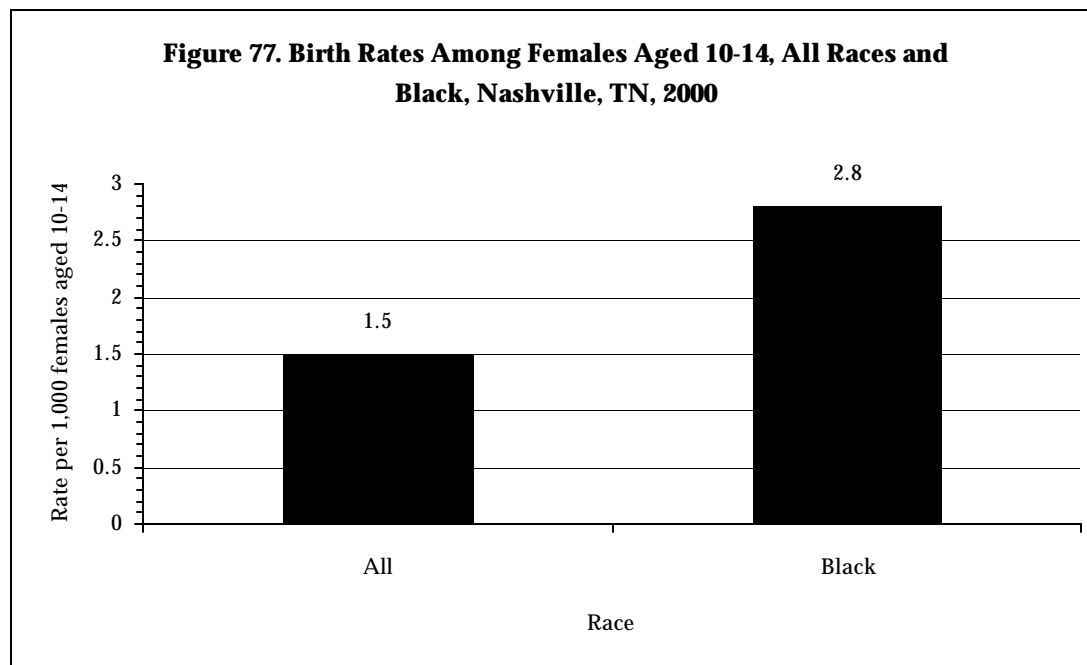
Births among those aged 10-17 do not exhibit the same amount of decline as among adolescents aged 15-19. As depicted in Figure 76, the overall rates for Nashville and for whites alone seem to be fairly stable over time. In 1990, 20 babies per 1,000 were born to teenaged mothers aged 10-17 overall. This rate has declined to nearly 17 babies per 1,000 in the year 2000, a decrease of 15%. White mothers aged 10-17 had approximately 13 babies per 1,000 in 1990 and in 2000. Black mothers aged 10-17, on the other hand, demonstrate a decline in birth rates, with approximately 33 babies per 1,000 in this age group in 1990, and approximately 26 babies per 1,000 in the year 2000, a decrease of 23%. Births to females of other races were excluded from this analysis due to extremely small numbers and unreliable rate estimates.



Births to Females Aged 10-14

Although adolescent females aged 10-14 contribute relatively few births to the overall adolescent pregnancy rate, the consequences of pregnancy for this age group are likely to be more severe than in older adolescent females.⁵ A female in this age group is less developed cognitively and biologically than her older adolescent counterpart.⁶ In addition, a girl who becomes pregnant at this age is more likely to bear more children while still in her teens than older adolescent females.⁷

In Nashville, there were nearly 2 babies per 1,000 females aged 10-14 in the year 2000 (Figure 77). There were so few babies born to white females and females of other races in this age group that they were excluded from further analysis. Black teenage females experienced a higher birth rate than the overall rate with nearly 3 babies per 1,000 females aged 10-14. Both rates are higher than the birth rate for females aged 10-14 in the United States (0.9).⁴



Comparing Nashville's data with that of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, and Tennessee, yields observations similar to those noted for teen births to females aged 15-19 and 10-17 (Figure 78). All rates discussed below are per 1,000 females aged 10-14. The birth rate for adolescent females aged 10-14 in Nashville (1.5) is slightly higher than the birth rates for Knox County (1.1) and Tennessee (1.2). Both Hamilton (1.8) and Shelby (2.4) Counties have birth rates higher than Nashville.

There is a large disparity between the overall birth rates and the rates for blacks in the geographic areas under consideration. Each county, as well as Tennessee, has a lower overall rate of teen births than black teen births in this age group. Further examination reveals that Hamilton County has the highest rate of black births (5.0) to females aged 10-14. Nashville has the lowest rate of black teen births (2.8) for this age group, while Knox (3.9) and Shelby (3.6) Counties, as well as Tennessee (3.2) fall between those two extremes.

There has been a declining trend in births to females aged 10-14 for the past ten years, both overall and for blacks. This declining trend, however, has much variation, as well as a drastic decline from 1996 to 1997. It is unknown if this fluctuation is the result of the small number effect or the result of an actual community phenomenon (Figure 79).

In the year 2000, there were approximately 59 babies born for every 1,000 females aged 15 - 19 in Nashville; approximately 17 babies born for every 1,000 females aged 10 - 17; nearly 2 babies per 1,000 females aged 10 - 14; and nearly 33 babies per 1,000 females aged 10 - 19.

Figure 78. Birth Rates Per 1,000 Females Aged 10-14, All Races and Blacks, Selected Counties and Tennessee, 2000

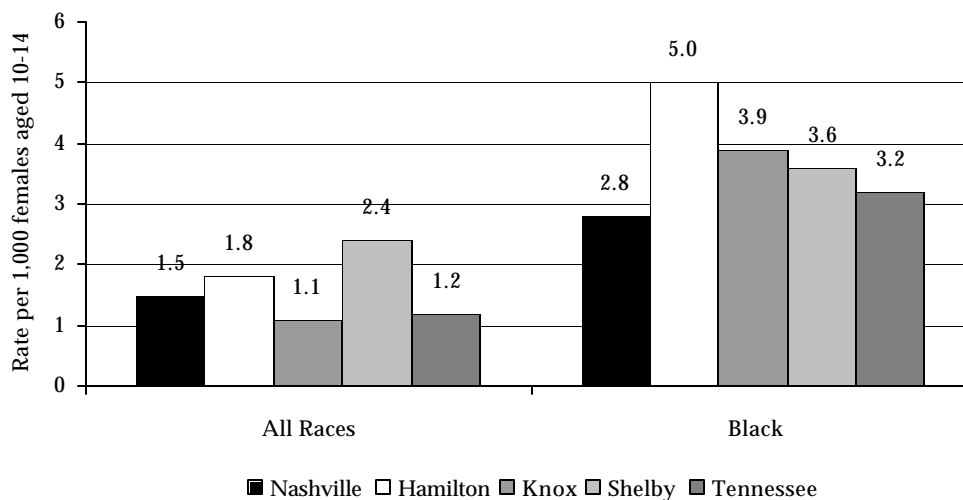
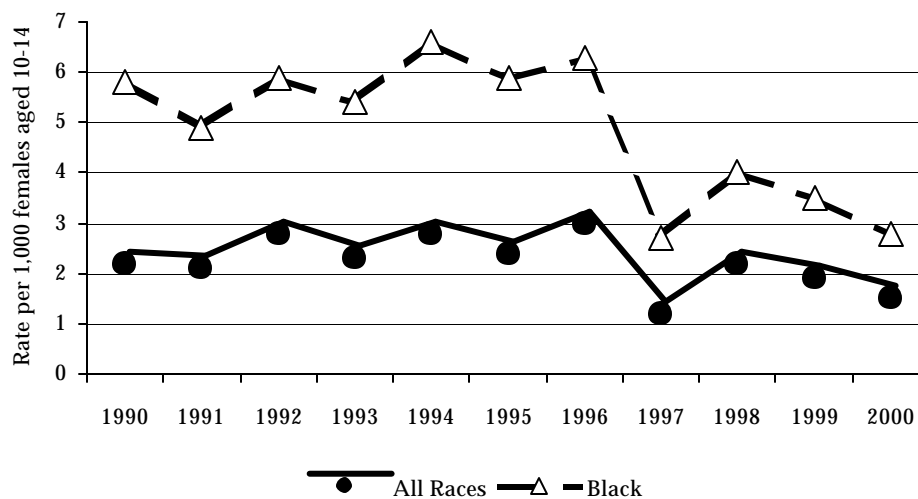


Figure 79. Birth Rates Among Females Aged 10-14, All Races and Black, Nashville, TN, 1990-2000

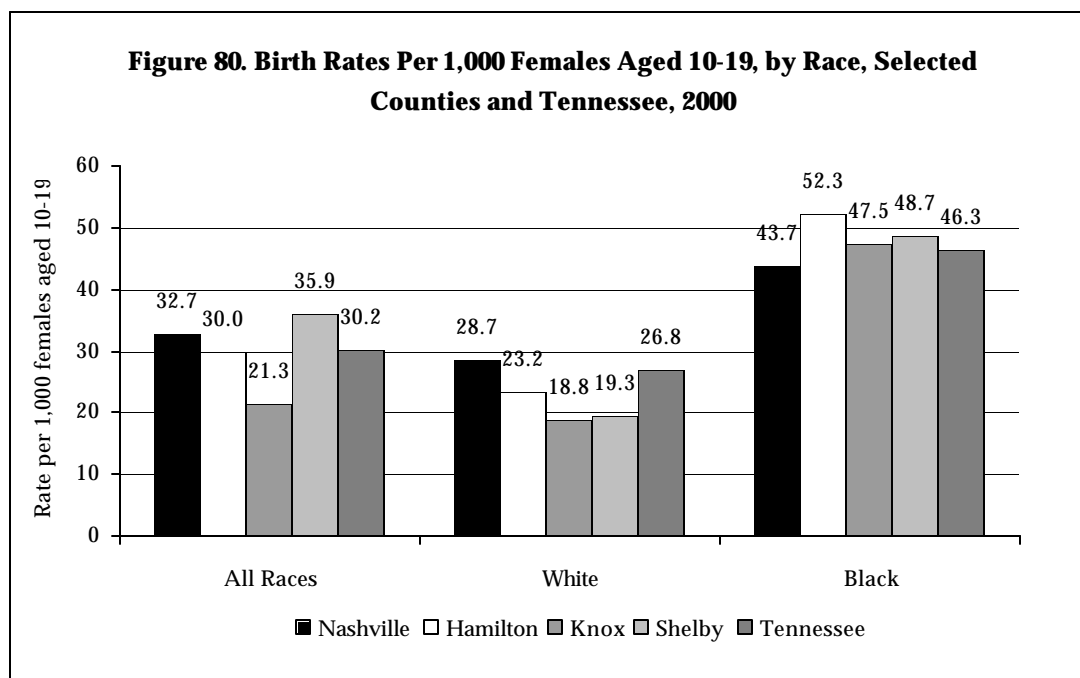


Births to Females Aged 10-19

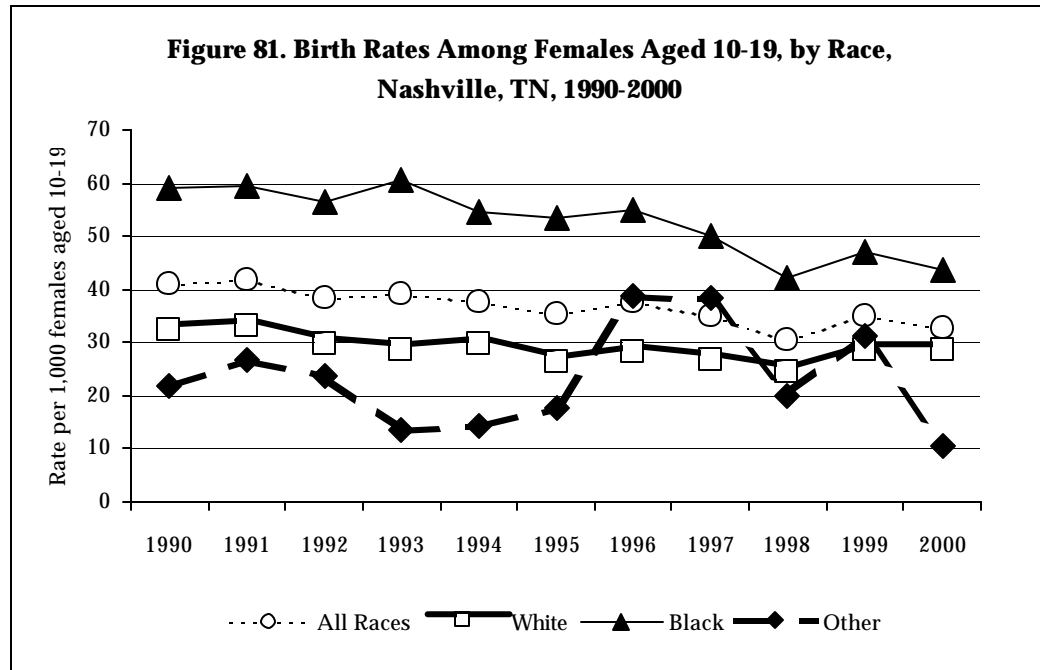
Examining adolescent births as an entire group yields results similar to those noted previously. In Nashville, there were nearly 33 births per 1,000 females aged 10-19 during the year 2000. This rate is not evenly distributed across the races, as is illustrated in Figure 80. Females of other races experienced the lowest birth rate with approximately 11 babies born per 1,000 females aged 10-19. Whites had a rate of approximately 29 per 1,000 females, and blacks had the greatest number of births yielding a rate of nearly 44 babies per 1,000 females aged 10-19.

Comparing Nashville's data with that of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, and Tennessee, yields observations similar to those noted for teen births to females aged 15-19, and 10-17. All rates discussed below are per 1,000 females aged 10-19. The birth rate for adolescent females aged 10-19 in Nashville (32.7) is second only to the birth rate in Shelby County (35.9). Knox County has the lowest rate of births for this age group (21.3), with Hamilton County (30.0) and the Tennessee rate (30.2) approximately the same.

There is a large disparity between the overall birth rates and the rates for blacks in the geographic areas under consideration. Each county, as well as Tennessee, has a lower rate of white teen births than black teen births in this age group. Further examination reveals that Nashville has the highest rate of white births (28.7), and Knox County has the lowest (18.8). Shelby County has a white birth rate (19.3) slightly higher than that of Knox County. For black births to females aged 10-19; however, Hamilton County has the highest rate (52.3), and Nashville has the lowest (43.7).



As depicted in Figure 81, the birth rates for teen females aged 10-19 exhibit a slow decline during the past decade. Blacks consistently have the highest birth rates, although this trend also demonstrates a slow decline. Birth rates for females of other races aged 10-19 demonstrate a great deal of variation during the past ten years. Although graphically, it appears the birth rate has great fluctuations from year to year, this variation is most likely due to unstable rate estimates resulting from the small number of births to females of other races in Nashville.



Repeat Births To Teens Aged 10-19

The efficacy of public health family planning programs among the teenage population can be evaluated by examining adolescents with subsequent pregnancies. As indicated in Table 19, the percentage of teens aged 10-19 with repeat births in Nashville is roughly 30%. In 1998, 32.2% of teenage mothers had a repeat birth. In 1999, that percentage dropped slightly to 24.6% but increased in 2000 to 31.2%.

Dissimilar to the data examined thus far, the disparity between white and black teenage mothers for this indicator is not very large. Furthermore, the disparity appears to be decreasing instead of increasing. In 1998, 38.5% of black teenage mothers had a repeat birth, compared to 26.2% of white teenage mothers. In 1999, 29.4% of black teenage mothers had a repeat birth compared to 20.3% of white teenage mothers. In the year 2000, however, the disparity declined significantly, with 33.3% of black teenage mothers having a repeat birth compared to 29.3% of white teenage mothers.

Table 19. Number and Percentage of Teenage Births that Are Repeat Births by Race, Nashville, TN, 1998-2000

Year	All Races		White		Black		Disparity*
	Number	Percentage	Number	Percentage	Number	Percentage	
1998	402	32.2	166	26.2	229	38.5	46.9
1999	289	24.6	122	20.3	161	29.4	44.8
2000	358	31.2	166	29.3	184	33.3	13.7

Total may include events with race other than white or black

*The disparity is the percentage difference between whites and blacks. It is calculated as follows: $((\% \text{black} - \% \text{white}) / \% \text{white}) \times 100$. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Discussion

Adolescent birth rates in Nashville show considerable variation by race. Black adolescent females consistently have higher birth rates than either white females or females of other races of the same age. In 2000, the birth rate for black females aged 10 - 19 is approximately 50% higher than the rate for white females the same age. This disparity has been in evidence for the past decade, and little to no reduction in the size of the gap is indicated.

Additionally, there is a consistent pattern of increasing birth rate by maternal age during the adolescent years. Overall, in Nashville, an adolescent female aged 15 - 19 is nearly 40 times more likely to give birth than an adolescent aged 10 - 14. Among blacks, females aged 15 - 19 are nearly 29 times more likely to bear a child than their 10 - 14 year old counterparts.

Teenage birth rates have been slowly declining over time. In Nashville, the rate in 1990 for 10-19 year olds was 40.9 per 1,000 females. By the year 2000, the birth rate had decreased to 32.7 per 1,000, a 20% decrease. From 1990 to 2000, the birth rate for whites aged 10-19 decreased 11.7%. During the same time frame, the birth rate for blacks decreased 26%, and the birth rate for females of other races decreased 51.8%.

The declines in teenage birth rates in Nashville mimics the national trend.¹ Although the exact causes of the decline are not known, possible contributing factors include adolescent pregnancy prevention efforts, higher rates of contraceptive use, and greater economic opportunities for teenagers during the 1990's.³

In order to address teenage pregnancy in Nashville, MPH D facilitates the Nashville Adolescent Pregnancy and Prevention Council (NAPPC). This organization is a community coalition comprised of representatives from various agencies, businesses, and organizations working together to address the issues of adolescent pregnancy and prevention in Nashville. NAPPC participates in, and hosts, community and school health fairs, and has produced and aired community awareness messages on television. The group also hosts an annual "Best Practices" conference for professionals working with youth. For more information or to join this organization contact Sheryl Wynn, Regional Coordinator for the Tennessee Adolescent Pregnancy Prevention Program and Community Liaison for NAPPC, in the Division of Health Promotion at MPH D.

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Adolescent birth rates in Nashville, show considerable variation by race. Black adolescent females consistently have higher birth rates than either white females or females of other races the same age.

Related Indicators

- Prenatal care
- Perinatal and infant mortality
- Maternal mortality

3.2.2 Fertility

Background

Fertility is defined as the birth rate of a community during a specific year. It measures the ratio between the number of live births in the community during a specified time period and the number of females of childbearing age in the population. It is important to note that fetal deaths and stillbirths are not counted as live births, and are therefore, excluded from this analysis. The fertility rate is calculated by dividing the number of live births in a population by the number of women of childbearing age, and multiplying the result by 1,000.¹

The fertility rate of a population is believed to be influenced by a multitude of behavioral and biological factors, including exposure to contraception and intercourse, and factors that impact pregnancy.² The degree of fertility in a community is an important public health issue. Proper planning for future population growth ensures continuing access to public services and healthcare. On the other hand, uncontrolled growth can negatively impact economic and environmental health, thereby leading to negative effects on a population's physical health.³

Findings***Births to Females Aged 15-44***

In the year 2000, 8,946 babies were born to females aged 15-44 in Nashville. The birth rate for all races combined for that year is approximately 64 babies born per 1,000 females in this age group.

Additional Data

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Data Sources

- Metro Public Health Department
- Tennessee Department of Health

Figure 82. General Fertility Rates for Females Aged 15-44 by Race, Nashville, TN, 2000

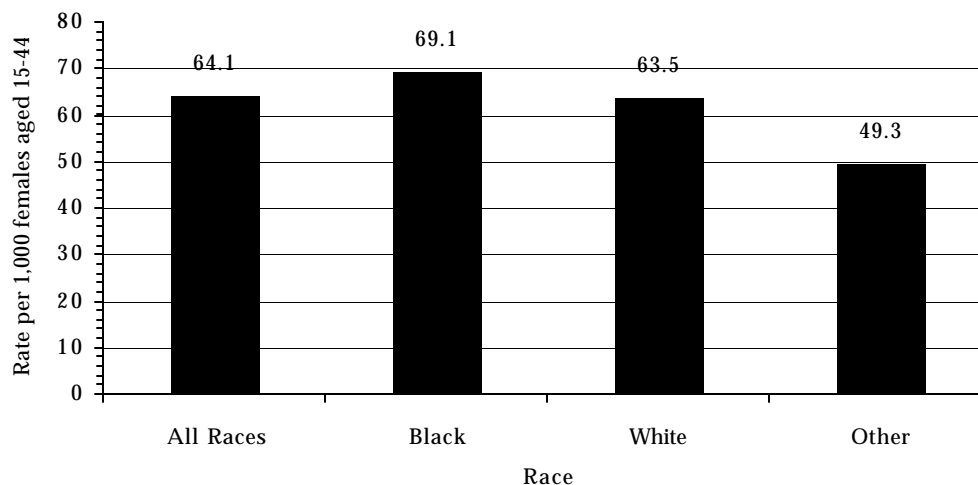
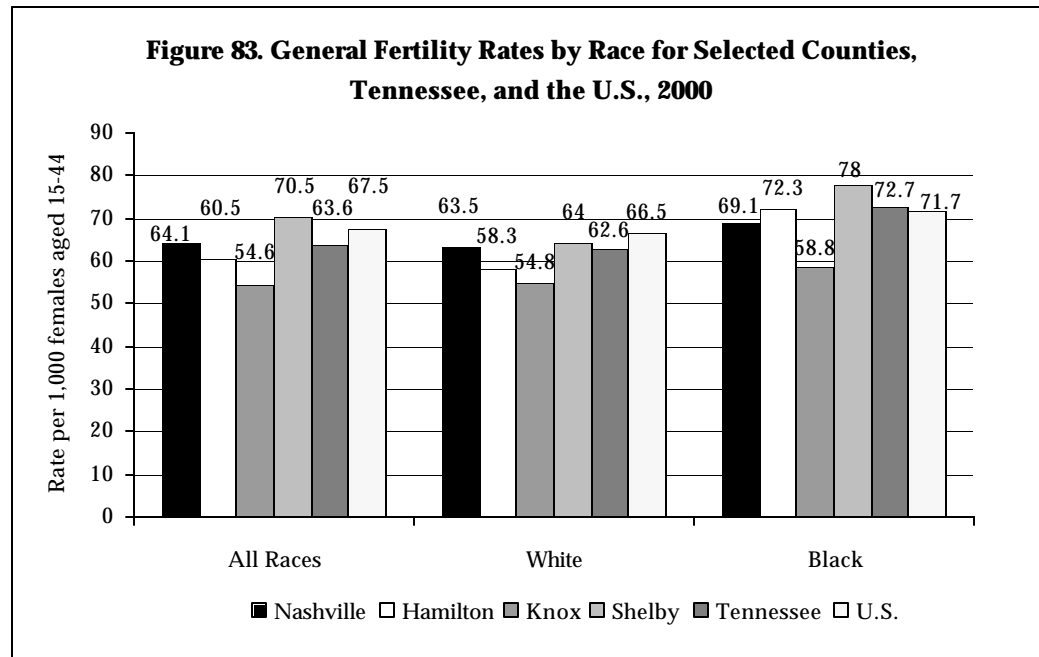


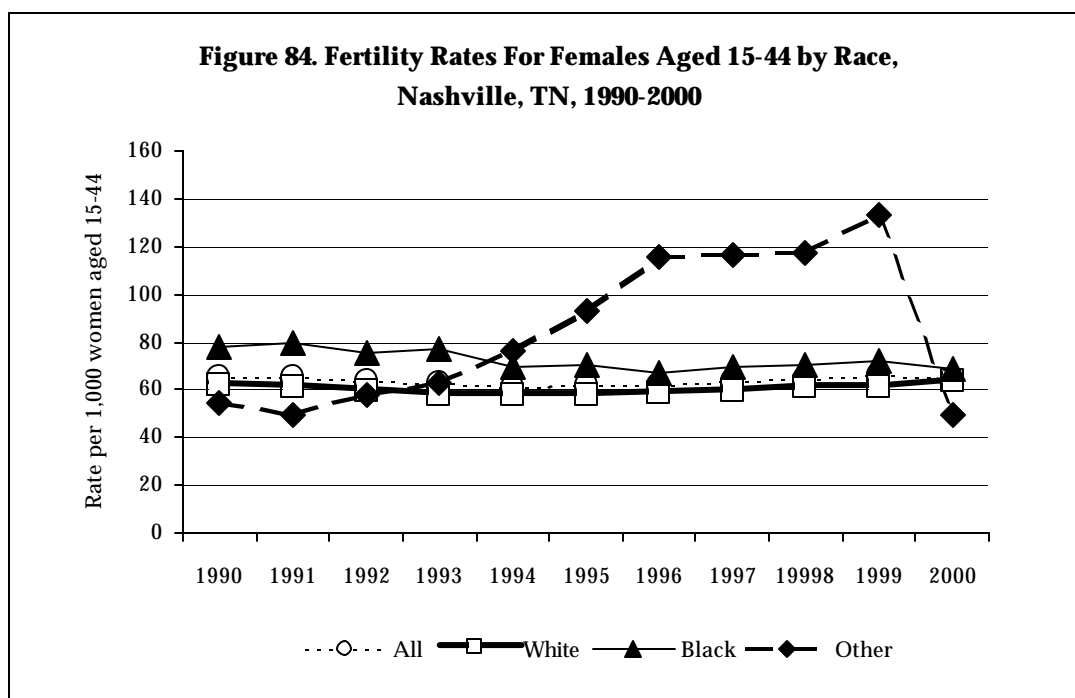
Figure 82 depicts fertility rates by race for the year 2000. Blacks have a slightly higher rate than whites or all races combined. Females of other races have a birth rate much lower than any of the previous categories.

Comparing Nashville's fertility rates with that of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S. yields some important observations (Figure 83). All rates discussed are per 1,000 females aged 15-44. The fertility rate in Nashville (64.1) is slightly higher than that of Tennessee (63.6), but is lower than both the U.S. (67.5) and Shelby County (70.5). Knox County has the lowest fertility rate of 54.6 per 1,000 females aged 15-44.



Examining the differences in fertility rates by race indicates that Knox County has the lowest fertility rate for whites (54.8). All the counties being compared, as well as Tennessee, have fertility rates for whites that are lower than the U.S. rate (66.5). A different picture emerges for blacks, however. Knox County, again, has the lowest fertility rate (58.8). Nashville has a fertility rate for blacks (69.6) that is lower than both the Tennessee rate (72.7) and the rate for the U.S. (71.7). Shelby County has the highest black fertility rate (78.0) of all the geographical areas compared.

Figure 84 depicts the fertility rate in Nashville for 1990-2000, overall and grouped by race. On average, the birth rate in Nashville has been steady throughout the past decade. The rates for blacks are consistently higher than the overall rate, while the rates for whites are consistently lower. Although the rate for women of other races appears to have both steep inclines and declines, this is most likely attributable to the effect of small numbers and unreliable fertility rate estimates.



Births to Unmarried Females

Marital status has long been recognized as being associated with pregnancy outcome most likely because babies of unmarried mothers tend to be of a lower birth weight⁴ and at a higher risk of infant mortality than babies of married mothers.⁵ Unmarried females tend to have more risk factors associated with poor pregnancy outcome.⁶ For example, unmarried females are less likely to obtain prenatal care in the first trimester of pregnancy than married females.⁷

It is important to note, however, that it is extremely unlikely that legal marital status causes any of the aforementioned outcomes. Marital status is most likely a surrogate marker for other unmeasurable social and economic risk factors.

In the year 2000, 39.4% of all live births were to unmarried mothers (Figure 85). Black females had the highest percentage by far, with nearly 69% of live births occurring to unmarried mothers. White females and females of other races had roughly the same percentage with 26% for whites and 27% for females of other races.

Comparing the percentage of babies born to unmarried females in Nashville with the percentages of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S. yields some important observations (Figure 86). Shelby County had the highest percentage of live births to unmarried women (51.4%), and Knox County had the lowest (26.4%) of all geographic areas compared. Nashville had a higher percentage (39.4%) than Hamilton County (38.8%), and Tennessee (34.6%). However, only Shelby County had a percentage (51.4%) higher than the U.S. (45.2%).

Figure 85. Percentage of All Live Births to Unmarried Females by Race, Nashville, TN, 2000

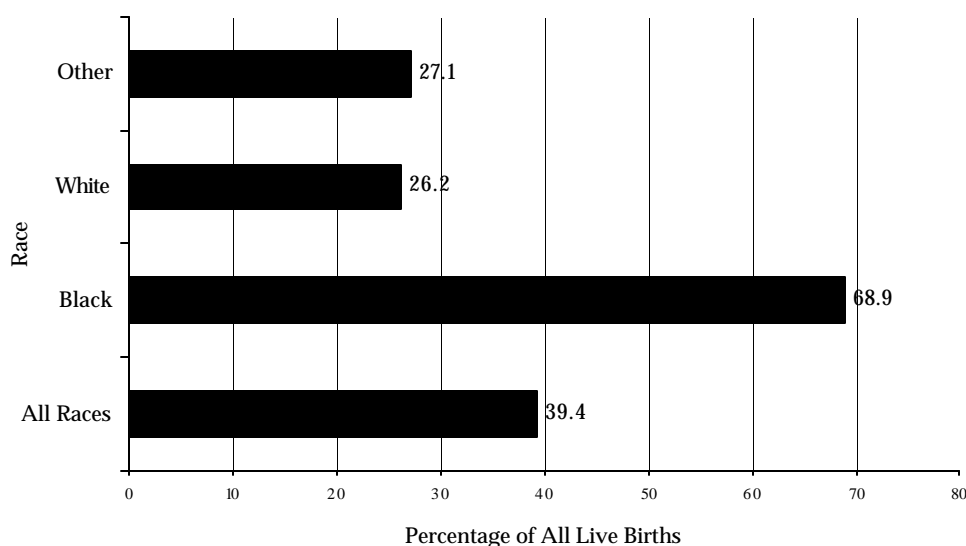
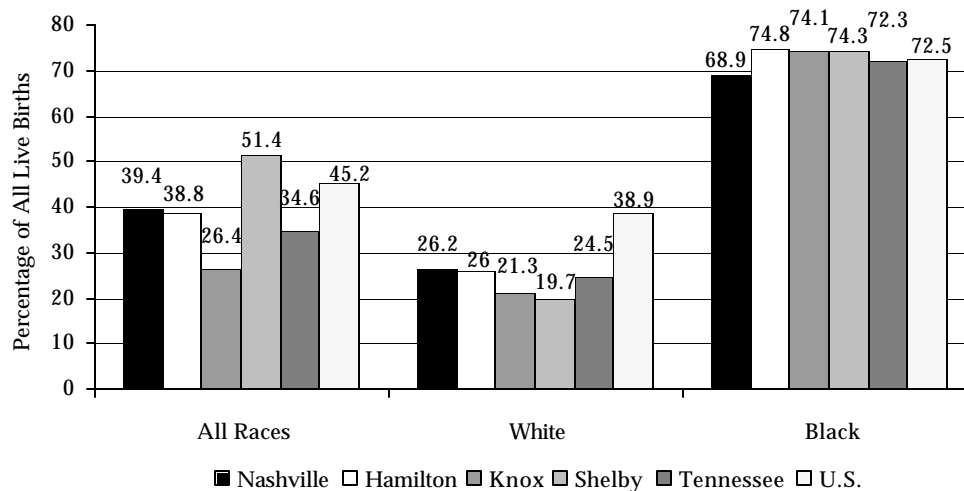


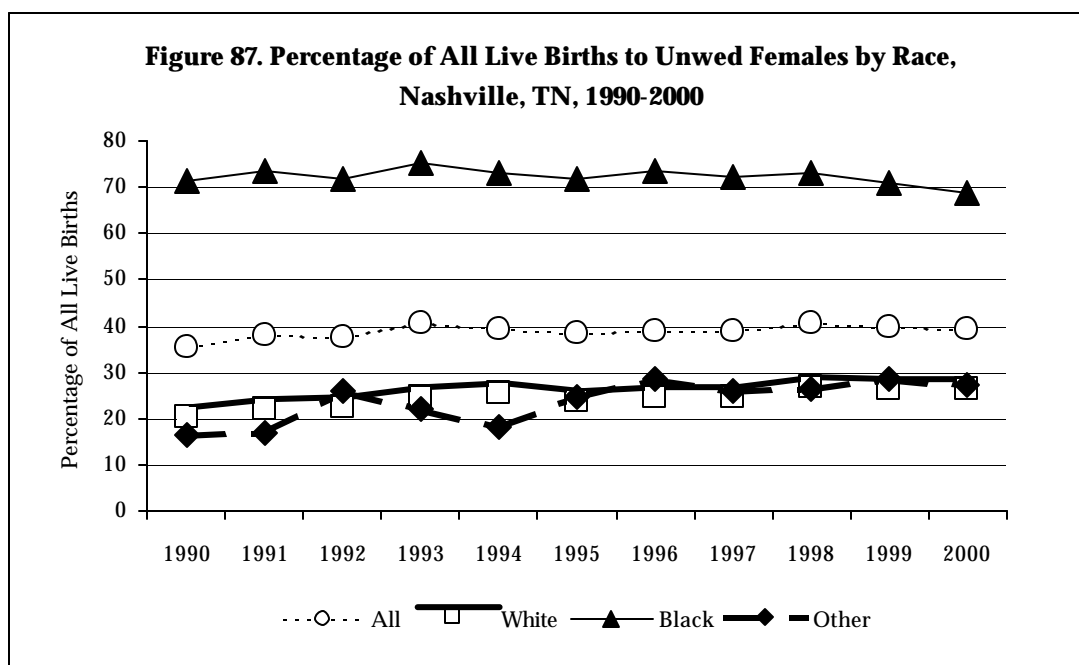
Figure 86. Percent of All Live Births to Unmarried Females by Race for Selected Counties, Tennessee, and the U.S., 2000



In the year 2000, 8,946 babies were born to females aged 15 - 44 in Nashville.

The percentage of all live births to unwed females demonstrates a great disparity by race. All the counties being compared, as well as Tennessee and the U.S., have lower percentages of live births to unmarried females for whites than for blacks. Shelby County had the lowest percentage for whites (19.7%), and all areas have lower percentages than the U.S. (38.9%). Nashville has a higher percentage (26.2%) of live births to white unmarried females than Tennessee (24.5%), but approximately the same percentage as Hamilton County (26%). For blacks, Nashville has the lowest percentage (68.9%) of all areas compared. Although Hamilton County has the highest percentage of live births to black unwed females (74.8%), Knox County (74.1%), Shelby County (74.3%), Tennessee (72.3%), and the U.S. (72.5%) all have approximately the same percentages.

Percentages of live births to unmarried females have been remarkably stable throughout the past decade (Figure 87). Black percentages of live births to unmarried females seem stable at approximately 70%, while percentages for Nashville as a whole are approximately 40%. Percentages of live births to unmarried females for whites and females of other races have remained nearly equivalent, with an approximate percentage of 25 for both.



In Nashville, the percentage of live births to unmarried females increased slightly by 11% from 1990 to 2000. Similarly, the percentage increased for whites during the same time period by 27.8%. Percentages for blacks, however, decreased by 3.4% from 1990 to 2000. Females of other races had the greatest percentage increase of 65%.

Discussion

The fertility rate in 2000 was 64 babies per 1,000 females aged 15 - 44. This rate is higher than the rate for Tennessee, but lower than the rate for the U.S. Nashville's birth rate has been stable for the past decade. Despite the steady birth rate, however, the number of babies born each year is increasing, indicating population growth. In 1990, for example, there were 8,706 live births to females aged 15 - 44, compared to 8,946 babies born in the year 2000.

Since a direct indicator of socioeconomic status is unavailable in this dataset, the percentage of live births to unwed females is examined. According to the data, the percentage of infants born to unwed females increased during the past decade by 11%. The percentage for blacks decreased by 3.4%, while the percentages for whites and females of other races increased by 27.8% and 64% respectively. This may indicate that the percentage of infants being born into economically disadvantaged households is increasing in Nashville. Further studies linking births with a better measure of socioeconomic status are needed.

MPHD offers comprehensive, full-range family planning services at the Lentz, Woodbine, East, and Downtown Clinics. In addition to full physicals, MPHD offers screening for sexually transmitted diseases, all methods of birth control, health education on reproductive issues, and free pregnancy testing. For more information regarding these family planning services, please refer to the MPHD website located at <http://healthweb.nashville.org>.

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In the year 2000, 39.4% of all live births were to unmarried mothers. Black females had the highest percentage by far, with nearly 69% of live births occurring to unmarried mothers.

Related Indicators

- Fertility
- Perinatal and infant mortality
- Low birth weight
- Maternal mortality

Additional Data

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Data Sources

Metro Public Health
Department

3.2.3 Prenatal Care

Background

Prenatal care forms the cornerstone of services offered to pregnant females, and includes three components: risk assessment, medical treatment, and health education. It is well established that a relationship exists between prenatal care and birth outcomes.¹ Early and adequate care ameliorates the risk of low birth weight and preterm delivery. It also reduces both morbidity and mortality for the mother and her child. On the other hand, inadequate or no prenatal care is associated with increased risks of low birth weight, preterm delivery, and mortality of the mother and child.¹⁻³ Although all pregnant females are encouraged to get early and frequent prenatal care, those most in need of services but least likely to receive them tend to be younger, socially disadvantaged females. Not surprisingly, these are the very females with high risks for poor pregnancy outcomes.¹

Findings

Females Receiving First Trimester Prenatal Care

Early and adequate prenatal care improves the chances of giving birth to a healthy baby. The Healthy People 2010 Objective 16.6 is to have 90% of pregnant females accessing prenatal care within the first trimester of pregnancy. This indicator is defined as the number of females beginning prenatal care within the first three months of pregnancy, divided by the total number of females giving birth within a specified time period multiplied by 100.

Overall, approximately 84% of pregnant females in Nashville are entering prenatal care during the first trimester. In Nashville, white females have the highest percentage of first trimester care with approximately 86%, and black females are not far behind with 82.1%. Lastly, in Nashville, 77% of females of other races received prenatal care during the first trimester (Figure 88).

Comparing the percentages of females entering first trimester care in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S. yields some important observations (Figure 89). Nashville has a higher percentage (84.4%) of females accessing care during the first trimester of pregnancy than Hamilton County (83.7%), Shelby County (74.7%), Tennessee (81.4%), and the U.S. (83.2%). Knox County has the highest percentage of all areas compared (86.1%).

Examining the differences in first trimester care by race indicates that Knox County has the highest percentage for whites (87.9%) followed closely by Hamilton County (87.8%). Nashville has a percentage for whites (86.1%) higher than Shelby County (84.8%), Tennessee (84.6%), and the U.S. (85%). All areas under examination have higher percentages of first trimester care for whites than for blacks. Nashville has the highest percentage of black mothers accessing prenatal care in the first trimester of pregnancy (82.1%) than any of the other areas compared, including Tennessee (70.5%), and the U.S. (74.3%). Shelby County has the lowest percentage for blacks (67.8%).

Figure 88. Percentage of Females with Live Births Who Started Prenatal Care during the First Trimester by Race Compared to the Healthy People 2010 Objective, Nashville, TN, 2000

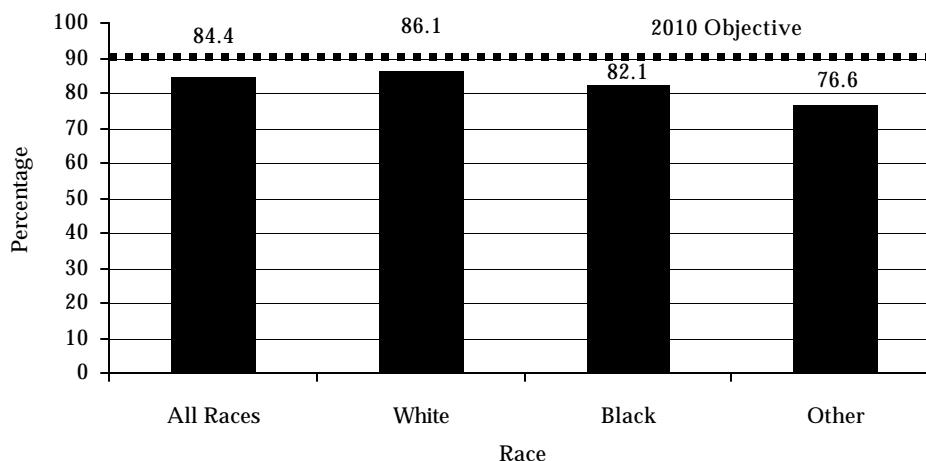
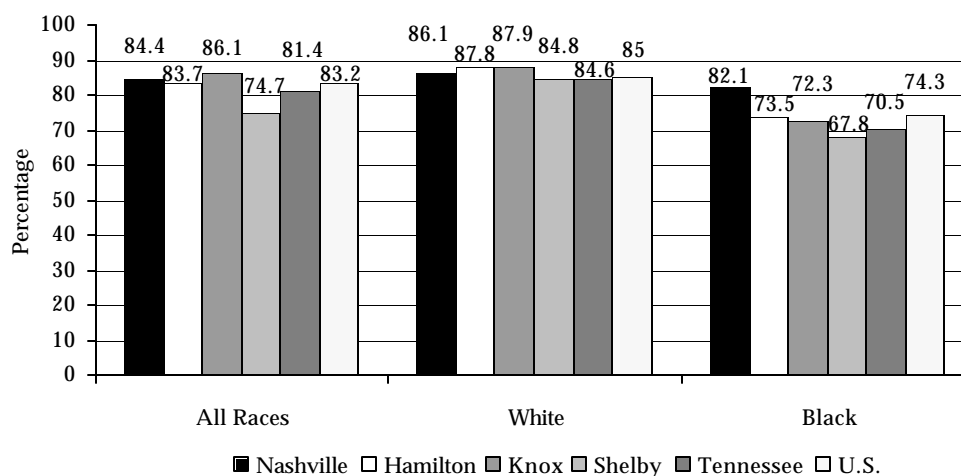


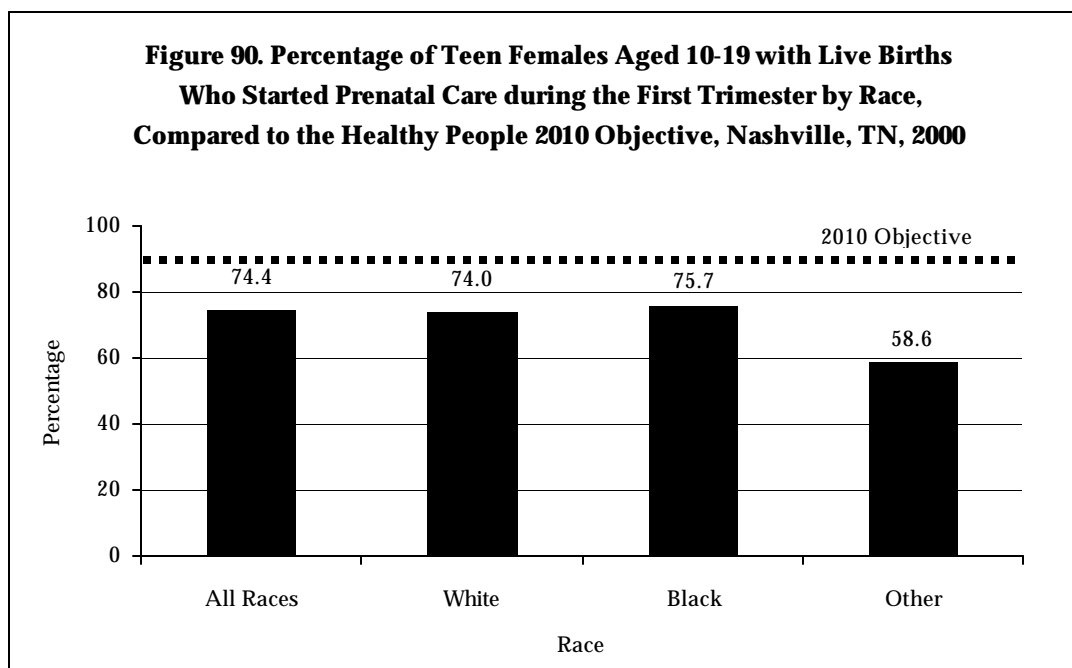
Figure 89. Percentage of Females with Live Births Who Started Prenatal Care during the First Trimester by Race, for Selected Counties, Tennessee, and the U.S., 2000



Overall, approximately 84% of pregnant females in Nashville are entering prenatal care during the first trimester.

In 2000, fewer teen mothers received early care compared to pregnant females in Nashville as a whole.

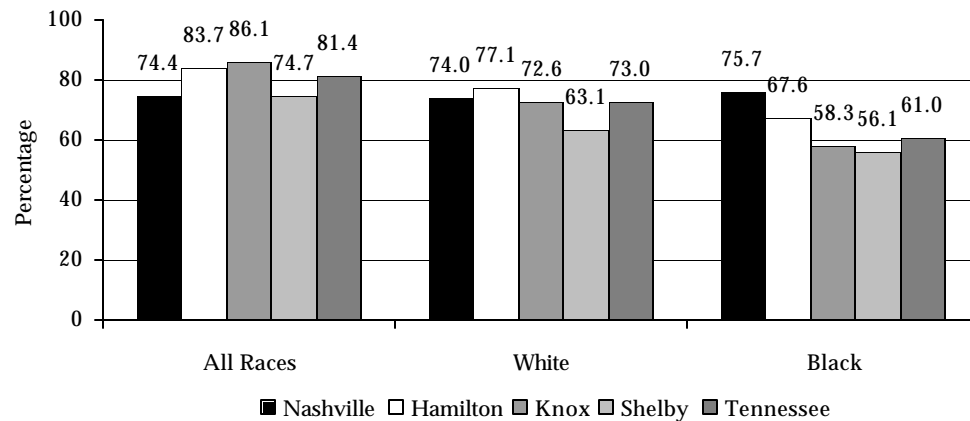
If we examine the data for mothers aged 10-19, the picture is less encouraging (Figure 90). Teen mothers are at risk for poor perinatal outcomes. Early prenatal care can provide these young mothers with nutritional counseling, STD screens, smoking cessation programs, and other services likely to improve the health of the mother and the child. In 2000, fewer of these teen mothers received early care compared to pregnant females in Nashville as a whole. The percentages of teen mothers who received first trimester prenatal care is 74.4%, a percentage considerably lower than the percentage of pregnant females as a whole (84.4%). Among teen mothers aged 10-19, more black females (75.7%) than white females (74.0%) received prenatal care in the first trimester. Only 58.6% of females of other races received first trimester prenatal care.



Comparing the percentages of females aged 10-19 entering first trimester care in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, and Tennessee, yields some important observations (Figure 91). Nashville has the lowest percentage (74.4%) of teen females accessing prenatal care during the first trimester of pregnancy of all areas compared. Knox County has the highest percentage (86.1%) of females aged 10-19 entering prenatal care during the first trimester of pregnancy.

Examining the differences in first trimester care by race indicates that Hamilton County has the highest percentage for whites aged 10-19 (77.1%). Nashville has a percentage for whites (74%) higher than Shelby County (63.1%), Knox County (72.6%), and Tennessee (73.0%). All areas under examination have higher percentages of first trimester care for whites than for blacks, with the exception of Nashville. Nashville has the highest percentage of black mothers accessing prenatal care in the first trimester of pregnancy (75.7%) than any of the other areas compared, including Tennessee (61.0%). Shelby County has the lowest percentage for blacks (56.1%).

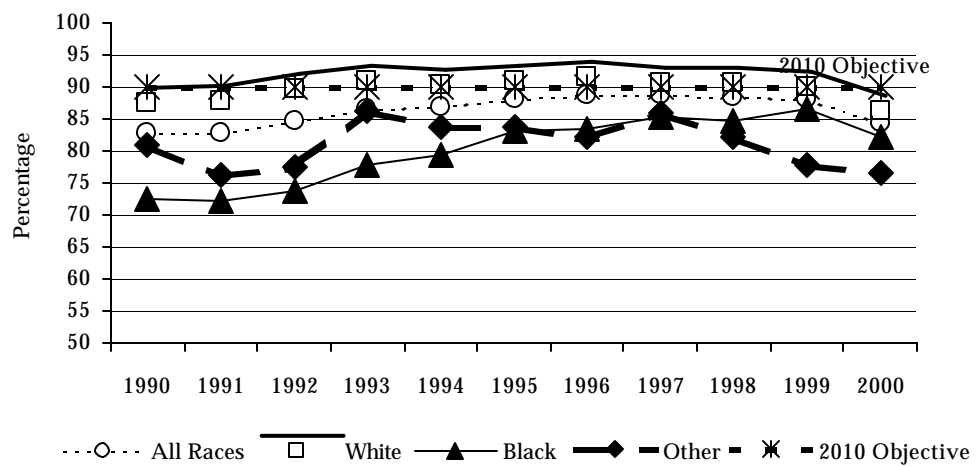
Figure 91. Percentage of Teen Females Aged 10-19 with Live Births Who Started Prenatal Care during the First Trimester by Race, for Selected Counties and Tennessee, 2000



Nashville has the lowest percentage (74.4%) of teen females accessing prenatal care during the first trimester of pregnancy of all areas compared.

Since 1990, there has been a steady increase in the percentage of females entering prenatal care during the first trimester of pregnancy. Despite this steady increase, however, the percentage for Nashville as a whole has not reached the 2010 objective. There seems to be a plateau of approximately 88%, which is seen during the years 1995 through 1999 (Figure 92).

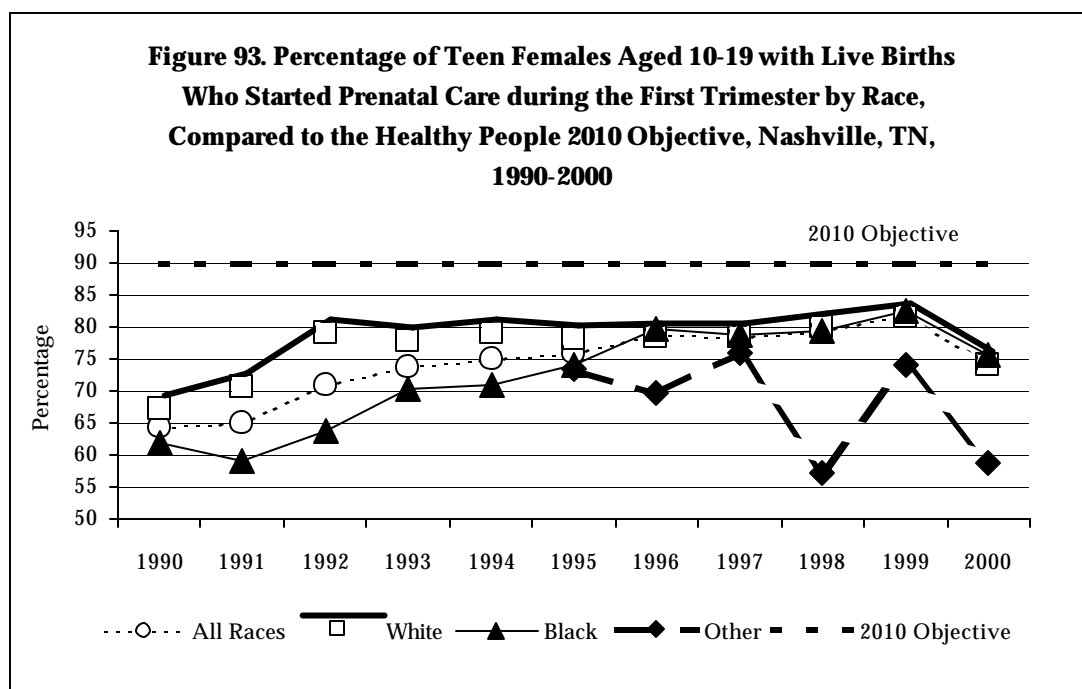
Figure 92. Percentage of Females with Live Births Who Started Prenatal Care during the First Trimester by Race, Compared to the Healthy People 2010 Objective, Nashville, TN, 1990-2000



The year 2000 data demonstrates a decrease of first trimester care among pregnant females from the 1999 level. This decline is apparent overall and in all racial groupings. It is unknown if this apparent decline is an aberration or the start of a declining trend.

Examining prenatal care by race, whites were the only group that reached the Healthy People 2010 objective of 90%. A plateau of approximately 90-91% occurred during 1993-1999, followed by a decrease in 2000. The highest percentage occurred in 1996 with 91.5% of white females beginning prenatal care during the first trimester. The greatest improvement can be found among blacks. In 1990, only 72.5% of black pregnant females started prenatal care in the first trimester. That number had risen to 86.7% by 1999. A 14.6% decrease is noted in the year 2000, decreasing from 86.7% in 1999 to 74.0% in 2000. Similarly, a downward turn is noted among females of other races, a percentage decrease of 5.3%. The trend in this group appears to be erratic, with the numbers ranging anywhere from 76.1% in 1991 to a high of 86.2% in 1993. The erratic behavior of the trend is most likely related to the small number effect and unreliable estimates more so than an actual trend.

The trend for pregnant females aged 10-19 presents a drastically different picture than the one for females in general (Figure 93). In this population, much work will be needed to achieve the Healthy People 2010 objective. Overall, the percentages for the 10-19 population who received first trimester care have been steadily increasing since 1990. This trend mimics the trend for Nashville as a whole. In 1990, only 64.4% of pregnant teenagers were beginning prenatal care during the first trimester of pregnancy. By 1999, however, this number had increased to 81.8% but fell to 74.4% by the year 2000, a decrease of 9%.



Overall, the percentages for the 10 - 19 population who received first trimester care have been steadily increasing since 1990.

Similar to the trends of the overall population, whites generally have the highest percentages of first trimester care during pregnancy, while black teens have the greatest amount of improvement during this time. By 1996, the numbers for white and black teens have become very similar. They mimic each other closely, including the downturn noticed in 2000.

Females Receiving Late or No Prenatal Care

In addition to recording the number of females entering prenatal care during the first trimester of pregnancy, Nashville also records the number of females who receive late or no prenatal care. Late or no prenatal care prevents early identification of mothers at high risk for poor perinatal outcomes such as preterm delivery, low birth weight, and congenital defects. Lack of early and adequate prenatal care also reduces the number of opportunities for maternal education on a wide range of topics concerning the health of both the mother and the child. Educational topics might include information on future pregnancy prevention, the prevention of birth defects, general nutrition, breastfeeding, and the signs and symptoms of preterm labor.

The importance of this measure is that it allows the identification of groups who most need access to services. Why females do not receive prenatal care is a complex issue. Potential barriers to care include: lack of access to the health care systems through physical or financial barriers, psychosocial barriers such as fear of stigma and lack of social support, and lack of education concerning the benefits of prenatal care.¹

In Nashville during the year 2000, 3.9% of pregnant females in Nashville received either late or no prenatal care. Examining the data by race shows that blacks have the highest percentage of females receiving either no or late prenatal care (5.5%). (See Figure 94.)

The pregnant teen population aged 10-19 has a higher percentage of late or no prenatal care than all pregnant females in Nashville (Figure 95). Overall, 6.7% of teen mothers are either starting care during the third trimester of pregnancy, or receiving no prenatal care. Blacks have a higher percentage of teens not receiving adequate prenatal care (8%), than whites (4.9%).

Comparing the percentages of females receiving late or no prenatal care in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S. yields some important observations (Figure 96). Shelby County has the highest percentage of females either starting care during the third trimester of pregnancy or receiving no care (8.0%). Nashville has a percentage (3.9%) equal to that of the U.S. (3.9%), and less than that of Tennessee (4.1%). Of all the areas compared, Knox County has the lowest percentage (2.9%) of pregnant females not receiving adequate care.

Blacks have the highest percentage of females receiving either no or late prenatal care. The pregnant teen population aged 10 - 19 has a higher percentage of no or late prenatal care than all pregnant females in Nashville.

Figure 94. Percentage of Females with Live Births Who Did Not Receive Prenatal Care or Began Care during the Third Trimester of Pregnancy by Race, Nashville, TN, 2000

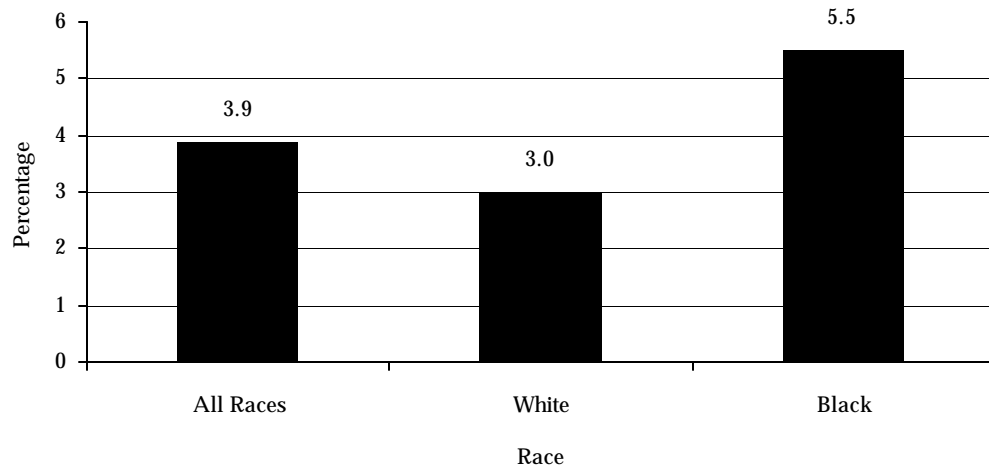
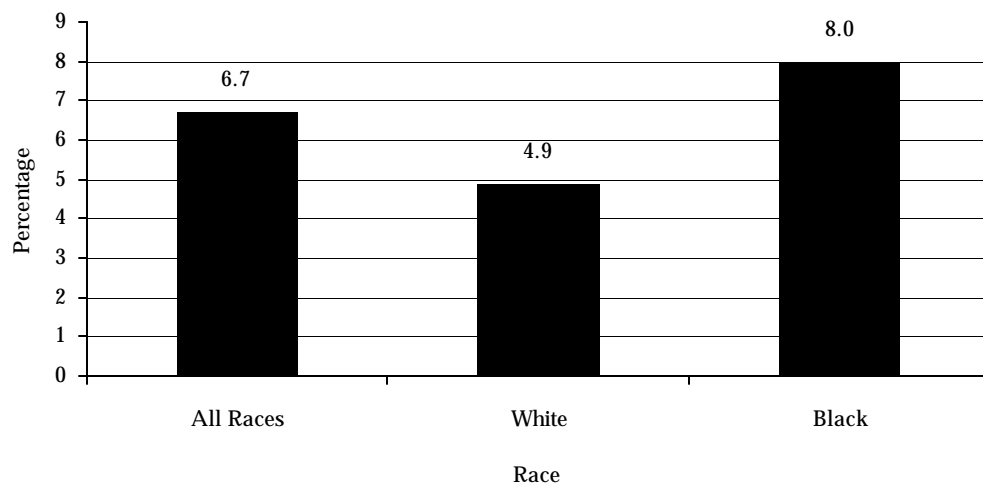
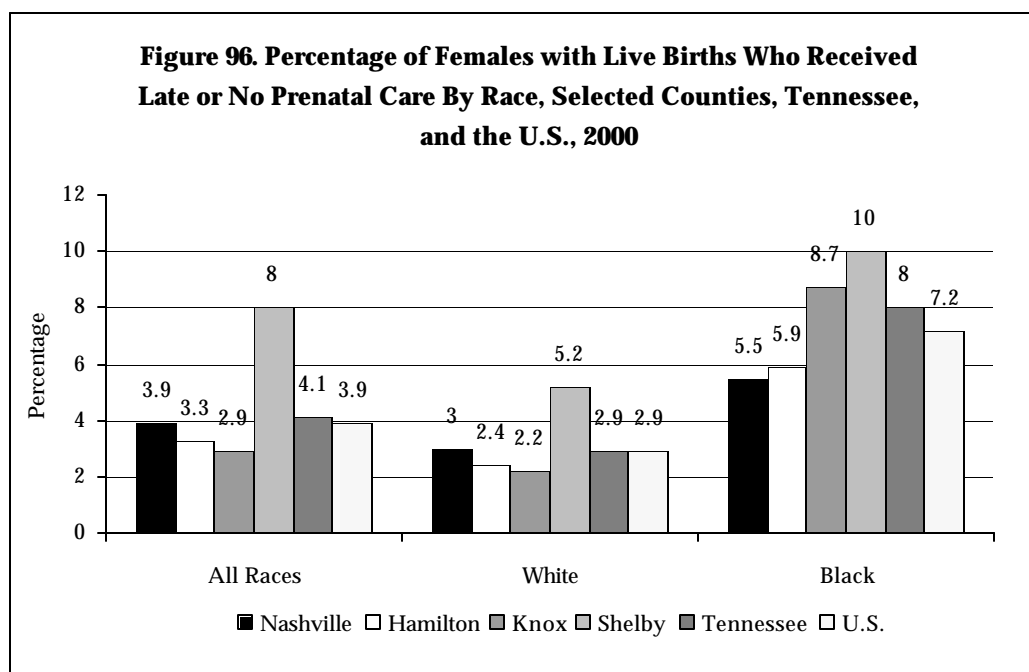


Figure 95. Percentage of Teen Females Aged 10-19 with Live Births Who Did Not Receive Prenatal Care or Began Care during the Third Trimester by Race, Nashville, TN, 2000

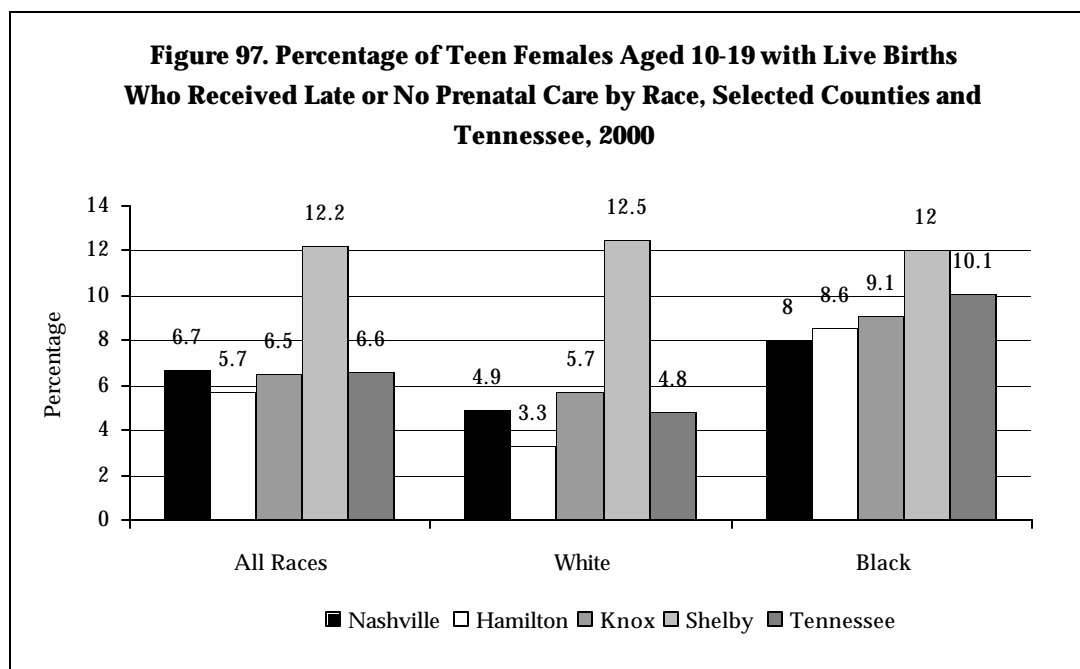




Examining the differences in late and no prenatal care by race shows that Shelby County has the highest percentage for whites (5.2%) and blacks (10.0%). All areas being compared have higher percentages of black females not receiving adequate prenatal care than white females. For whites, Nashville has a percentage (3.0%) nearly equivalent to that of Tennessee (2.9%) and the U.S. (2.9%). For blacks, Nashville has the lowest percentage of females receiving late or no prenatal care (5.5%) of all geographic areas compared, including Tennessee (8.0%) and the U.S. (7.2%).

Comparing the percentages of teen females aged 10-19 receiving late or no prenatal care in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S., yields further information (Figure 97). Shelby County has the highest percentage of teen females either starting care during the third trimester of pregnancy or receiving no care (12.2%). Nashville has a percentage (6.7%) slightly higher than that of Tennessee (6.6%). Of all the areas compared, Hamilton County has the lowest percentage (5.7%) of pregnant teens not receiving adequate care.

Examining the differences among teen females receiving late and no prenatal care by race shows that Shelby County has the highest percentage for whites (12.5%) and blacks (12.0%). (See Figure 97.) All areas being compared have higher percentages of black females not receiving adequate prenatal care than white females, excluding Shelby County. For white teen females, Nashville has a percentage (4.9%) nearly equivalent to that of Tennessee (4.8%). For blacks, Nashville has the lowest percentage of females receiving late or no prenatal care (8.0%) of all geographic areas compared, including Knox County (9.1%), and Tennessee (10.1%).



According to national data, the percentage of pregnant females who do not receive prenatal care is increasing.² As shown in Figure 98, the percentages of females either entering care during the third trimester of pregnancy or receiving no care has been slowly increasing since 1990. Blacks have the greatest percentage of females receiving late or no prenatal care followed by females of other races. Whites have the lowest percentages of all the comparisons. There is a slight downward turn for the year 2000, but it is unknown if this is an aberrant phenomenon or a precursor of things to come.

At first glance, the line graph depicting the trend of late or no prenatal care among females aged 10-19 is not nearly as smooth as the previous graph (Figure 99). The relative ranking mimics that seen among all pregnant females in Nashville. Blacks have the highest percentages, and whites have the lowest. 1998 is the only year that the black percentages become lower than the white percentages. Points of interest in this graph are the decreasing peaks in 1993 and 1998. It appears that each reduction in the percentage of teens receiving little or no prenatal care is followed in subsequent years by a corresponding increase in percentage. The last downward peak was in 1998. The percentages increased in 1999, and continue to increase for 2000.

Discussion

Early and adequate prenatal care improves the likelihood of giving birth to a healthy infant. The percentage of pregnant females receiving early care in Nashville is higher than the percentages for Tennessee and the U.S. In 2000, 84% of pregnant females in Nashville received prenatal care during the first trimester; 86% of whites, 82.1% of blacks, and 77% of females of other races. In order to achieve the Healthy People objective of 90% by the year 2010, Nashville will need to increase the number of pregnant women receiving early care by 7%; 4.7% for whites, 9.6% for blacks, and 16.9% for females of other races.

Figure 98. Percentage of Females with Live Births Who Received No Prenatal Care or Started Care during the Third Trimester by Race, Nashville, TN, 1990-2000

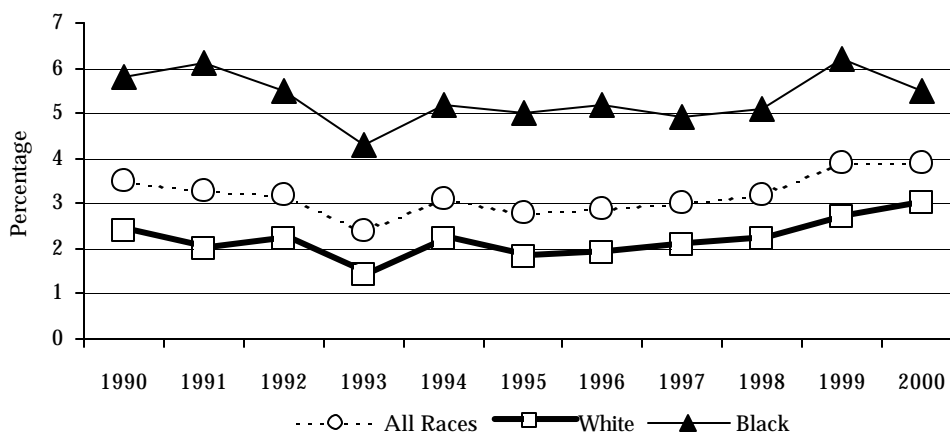
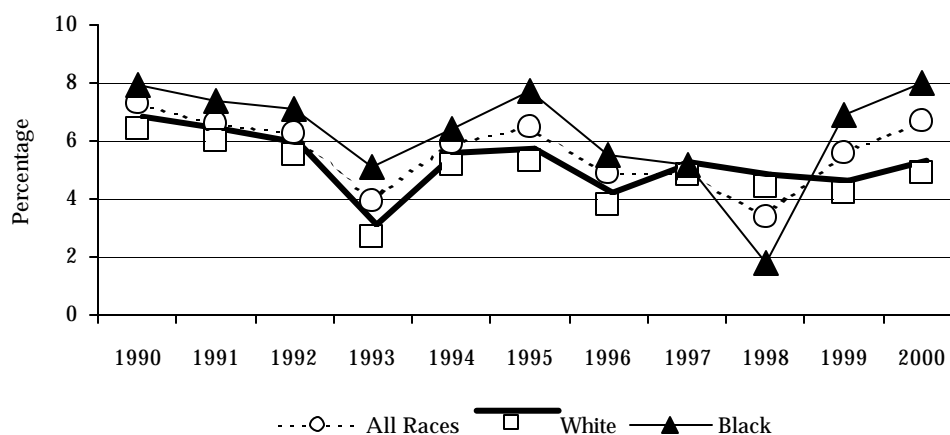


Figure 99. Percentage of Teen Females Aged 10-19 with Live Births Who Received No Prenatal Care or Entered Care during the Third Trimester by Race, Nashville, TN, 1990-2000



The percentage of pregnant females receiving early care in Nashville is higher than the percentages for Tennessee and the U.S.

The percentage of females aged 10 - 19 entering prenatal care is not as encouraging. Nashville's percentage of 74.4% is lower than the percentages of Hamilton, Knox, and Shelby Counties, as well as the percentage for Tennessee. Contrary to the trend overall, the percentage of black teens entering first trimester prenatal care is higher than the percentage of white teens. Teen females of other races have the lowest percentage of first trimester prenatal care. In order to achieve the Healthy People 2010 objective for teen females, Nashville will need to increase the number of pregnant teens receiving early care by 21%; 22% for white teens, 18.9% for black teens, and 53.6% for teens of other races.

For Nashville to improve the percentage of pregnant females receiving first trimester prenatal care, it will be important to identify the barriers that prevent pregnant females from accessing care. It is highly likely that the barriers for entry into early prenatal care are different for pregnant teens compared to older pregnant women. Further research is needed to identify and subsequently address those issues.

Although MPHD does not offer direct prenatal care services, pregnant women who meet the eligibility requirements may apply for the Women, Infants, and Children program (WIC). WIC participants receive nutritional counseling and supplemental nutritious foods, as well as screening and referrals to other health, welfare, and social services. Further information may be obtained at MPHD's website, <http://healthweb.nashville.org>.

References:

1. Kiely JL, Kogan MD. Prenatal care. In: Wilcox, LS, Marks, JS, eds. *Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children*. U.S. Department of Health and Human Services; 1995.
2. Centers for Disease Control and Prevention. Entry into prenatal care-United States, 1989-1997. *Morbidity and Mortality Weekly Report*. 49(18):393-8, May 12, 2000.
3. Centers for Disease Control and Prevention. Current trends state-specific trends among women who did not receive prenatal care – United States, 1980-1992. *Morbidity and Mortality Weekly Report*. 43; 939-942, December 23, 1994.

The percentage of females aged 10 - 19 entering prenatal care is not as encouraging. Nashville's percentage of 74.4% is lower than the percentages of Hamilton, Knox, and Shelby Counties, as well as the percentage for Tennessee.

Related Indicators

- Teen births
- Prenatal care
- Low birth weight
- Educational attainment
- Household income

3.2.4 Perinatal and Infant Mortality

Background

The death of a child is a complex issue related to a wide range of factors such as socioeconomic conditions, maternal lifestyle and health, access to and acceptability of medical care, and availability of services. Since fetal and infant mortality are related to many important issues, these measures are often used as indicators of the overall health of a community.

Fetal death, also referred to as stillbirth, has been officially defined by the World Health Organization (WHO) as “death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.”¹ States, however, differ on the recording requirements for fetal death. Tennessee requires all fetal deaths 500 grams and greater to be recorded. If the birth weight is unknown, then the fetal death must be at least 22 weeks of gestation.² The fetal death rate is calculated by dividing the number of fetal deaths in a year by the number of live births plus fetal deaths in that same year and multiplying the quotient by 1000.³

Additional Data

Appendices
pages D-49 - D-50

Infant mortality has a much clearer definition. It is defined as the death of a child before his or her first birthday. This indicator is further divided into two categories: neonatal mortality and postneonatal mortality. Neonatal mortality refers to the death of a child aged 0-27 days. Postneonatal mortality refers to the death of a child aged 28-364 days. The infant mortality rate is calculated by dividing the number of infant deaths in a time period by the number of live births in that same time period and multiplying the quotient by 1000.³

Findings

Fetal Mortality

The most recent fetal death data is from 1998 (Figure 100). In that year, the mortality rate for all races in Nashville was 5.4 per 1,000 live births plus fetal deaths. There is a very large disparity between blacks and whites. In 1998, blacks had a fetal mortality rate of 9.7 deaths per 1,000 live births plus fetal deaths, compared to whites with a fetal mortality rate of 3.2 deaths per 1,000 live births plus fetal deaths. Black fetuses are 3 times more likely to die than white fetuses.

The Healthy People 2010 objective is to reduce fetal mortality to 4.1 deaths per 1,000 live births plus fetal deaths. If we examine the trend for fetal mortality rates from 1990 to 1998 in Nashville, it appears that fetal mortality is worsening instead of improving (Figure 101). Since 1994, the disparity between blacks and whites appears to be getting larger, and the rate of fetal deaths for blacks is increasing. White rates have been consistently lower than the 2010 objective since 1995, and demonstrate no signs of increasing above the objective.

Data Sources

- Metro Public Health Department
- Tennessee Department of Health

Figure 100. Fetal Mortality Rates by Race of Mother, Nashville, TN, 1998

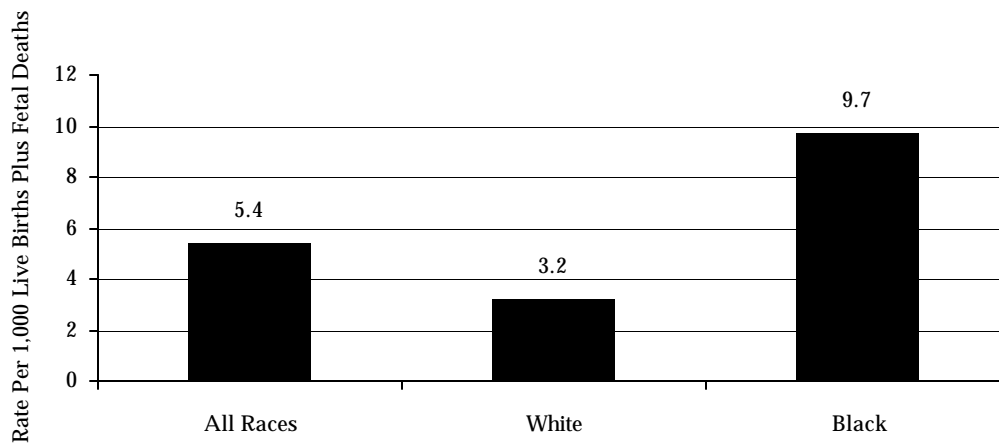
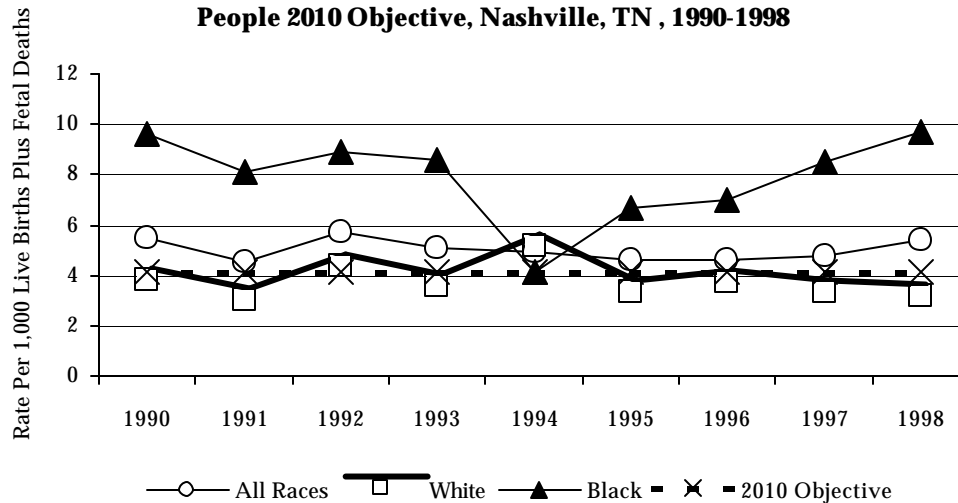


Figure 101. Fetal Mortality Rates by Race Compared to the Healthy People 2010 Objective, Nashville, TN, 1990-1998

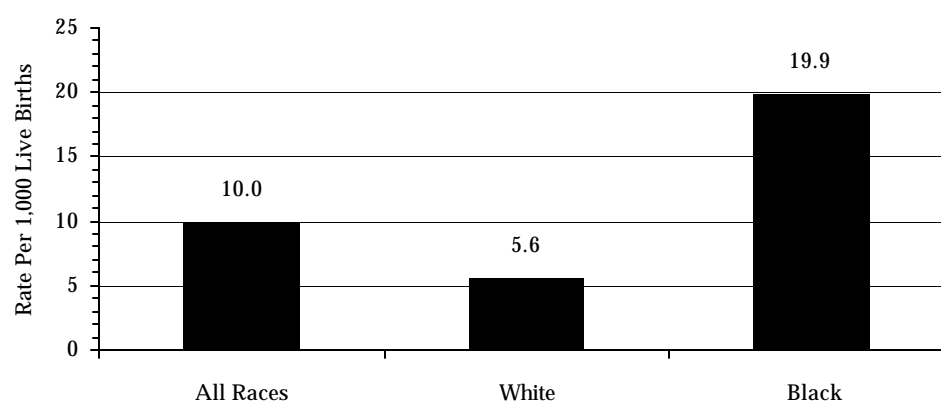


In 1998, black fetuses were 3 times more likely to die than white fetuses.

Infant Mortality

In the year 2000, the infant mortality rate for Nashville was 10.0 per 1,000 live births. When examined by race, a disparity between the rates for blacks and whites appears. White infants died at the rate of 5.6 per 1,000 live births, while black infants died at the rate of 19.9 per 1,000 live births. This means that black infants born in Nashville are 3.6 times more likely to die than white infants (Figure 102).

Figure 102. Infant Mortality Rates By Race of Mother, Nashville, TN, 2000

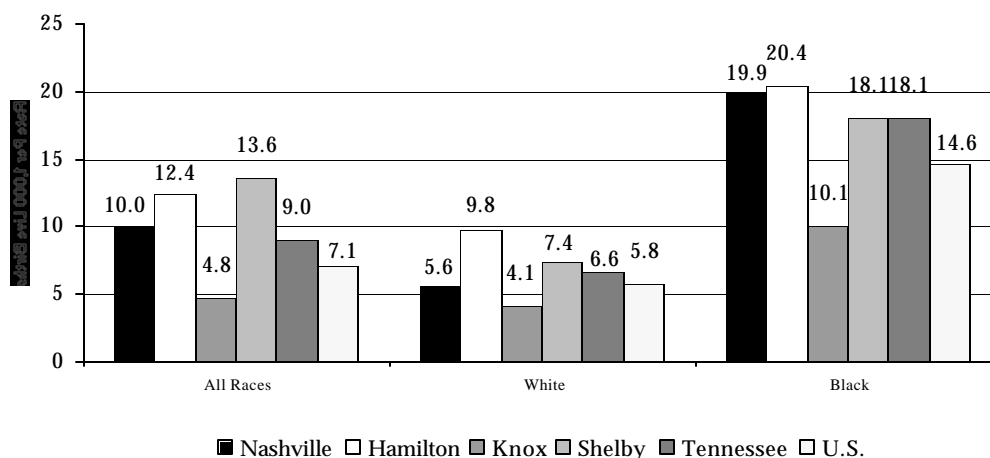


Black infants born in Nashville are 3.6 times more likely to die than white infants.

Comparing the infant mortality rates in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S., yields some important observations (Figure 103). All rates discussed are per 1,000 live births. Overall, Shelby County has the highest infant mortality rate (13.6), followed by Hamilton County (12.4). The infant mortality rate in Nashville is higher than the rate for either Tennessee (9.0) or the U.S. (7.1). Knox County has the lowest infant mortality rate of all areas compared (4.8).

Examining the differences in infant mortality rates by race reveals a large disparity between whites and blacks. This disparity is evident in all of the areas under comparison. Hamilton County has the highest rate for whites (9.8), followed by Shelby County (7.4). The infant mortality rate in Nashville for whites (5.6) is lower than both the rates for Tennessee (6.6) and the U.S. (5.8). Knox County has the lowest white infant mortality rate of all the areas compared (4.1). For blacks, Hamilton County has the highest infant mortality rate (20.4) followed closely by Nashville (19.9). Nashville has a higher black infant mortality rate than Shelby County (18.1), Tennessee (18.1), and the U.S. (14.6). Knox County has the lowest black infant mortality rate of all the areas compared (10.1).

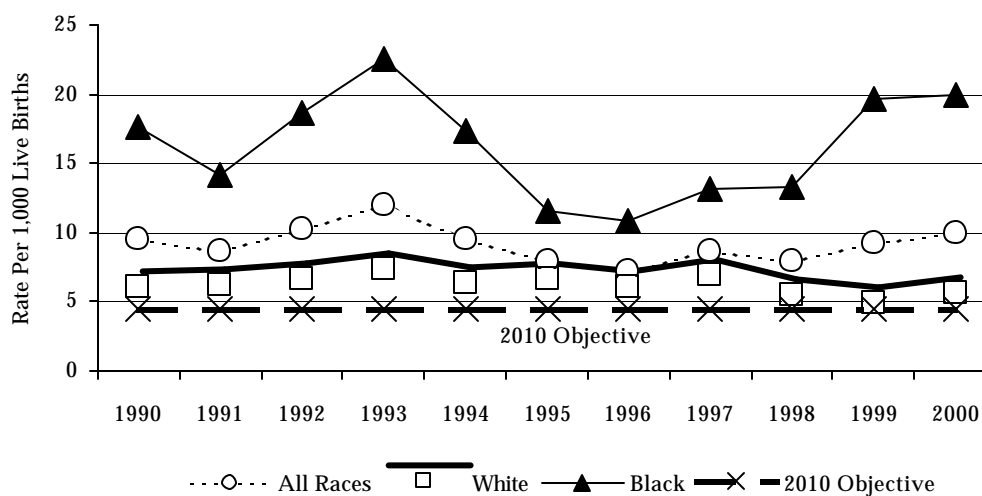
Figure 103. Infant Mortality Rates Per 1,000 Live Births, by Race of Mother, Tennessee and Selected Counties, 2000, and the U.S., 1999



Infant mortality rates in Nashville through the past decade are not improving.

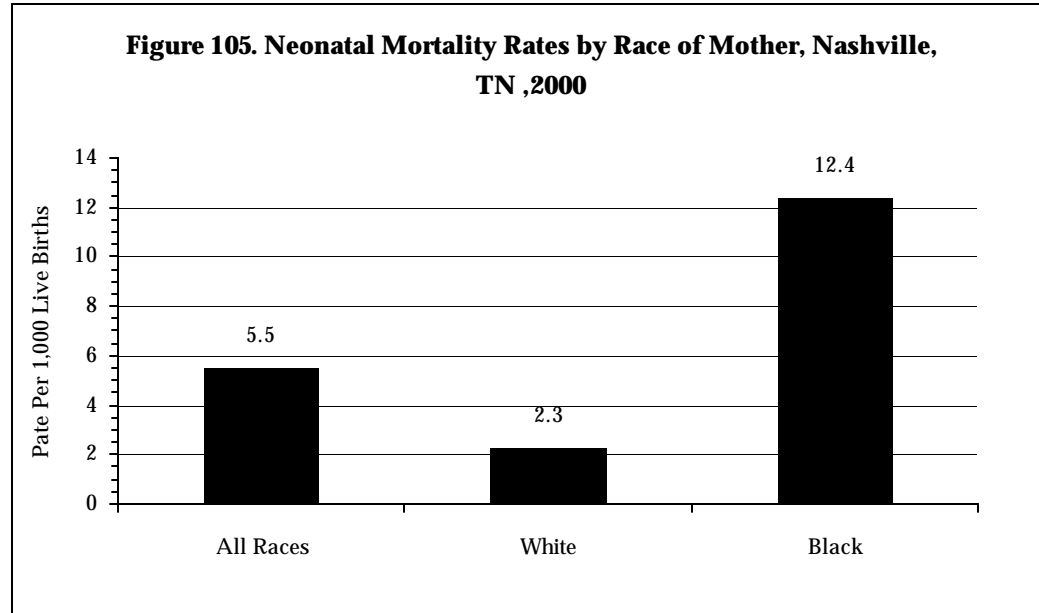
The Healthy People 2010 objective is to reduce infant mortality to 4.5 deaths per 1,000. Examining infant mortality rates through the past decade, as depicted in Figure 104, indicates that rates in Nashville are not improving. Infant mortality rates for all races are greater than the 2010 goal. Blacks have had the highest rate of infant mortality during the past decade, while whites have consistently had the lowest infant mortality rate. The white infant mortality rate appears to be stable at approximately 6 deaths per 1,000 live births, but the rate for blacks appears to have great variability.

Figure 104. Infant Mortality Rates by Race of Mother Compared to the Healthy People 2010 Objective, Nashville, TN, 1990-2000



Neonatal Mortality

Infant mortality is composed of two parts – neonatal mortality and postneonatal mortality. Neonatal mortality refers to the death of children aged 27 days and less. In 2000, Nashville had a neonatal mortality rate of 5.5 per 1,000 live births. White neonates die at the rate of 2.3 per 1,000 live births while neonatal black babies die at the rate of 12.4 per 1,000. Black neonates are 5.4 times more likely to die than white neonates (Figure 105).

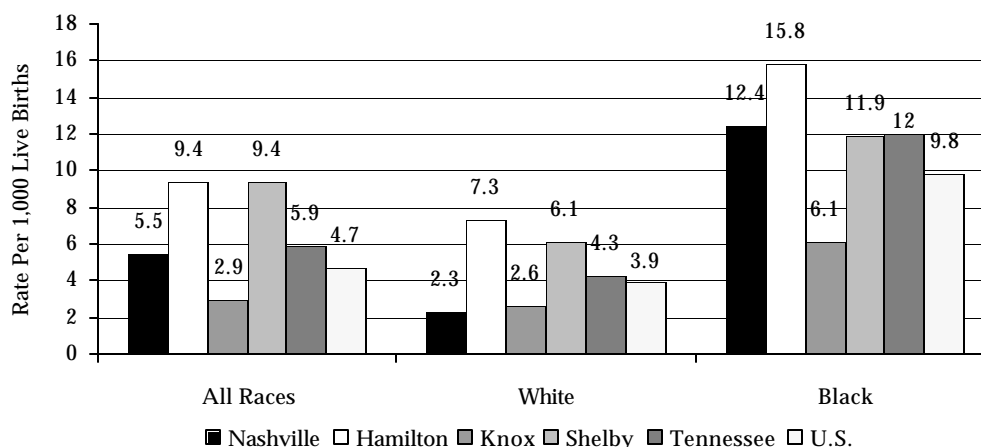


Black neonates are 5.4 times more likely to die than white neonates.

Comparing the neonatal mortality rates in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S. yields some important observations (Figure 106). All rates discussed are per 1,000 live births. Overall, Shelby and Hamilton Counties have the highest neonatal mortality rates (9.4). The neonatal mortality rate in Nashville is higher than the rate for the U.S. (4.7), but is lower than the rate for Tennessee (5.5). Knox County has the lowest neonatal mortality rate of all areas compared (2.9).

Examining the differences in neonatal mortality rates by race reveals a large disparity between whites and blacks. This disparity is evident in all of the areas under comparison. Hamilton County has the highest rate for whites (7.3) followed by Shelby County (6.1). The neonatal mortality rate in Nashville for whites (2.3) is lower than both the rates for Tennessee (4.3), and the U.S. (3.9). Nashville has the lowest white neonatal mortality rate of all the areas compared (2.3). For blacks, Hamilton County has the highest neonatal mortality rate (15.8) followed by Nashville (12.4). Nashville has a higher black neonatal mortality rate than Shelby County (11.9), Tennessee (12.0), and the U.S. (9.8). Knox County has the lowest black neonatal mortality rate of all the areas compared (6.1).

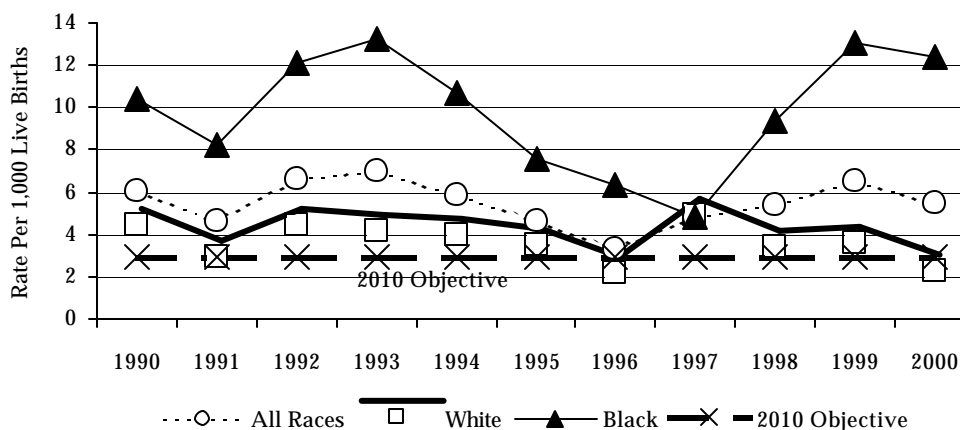
Figure 106. Neonatal Mortality Rates Per 1,000 Live Births, by Race of Mother, Tennessee and Selected Counties, 2000, and the U.S., 1999



In general, the neonatal mortality rates for Nashville are twice as high as the 2010 objective; the black neonatal mortality rate is nearly 4 times higher than the objective.

The Healthy People 2010 Objective is to reduce the neonatal mortality rate to 2.9 deaths per 1,000 live births. Examining neonatal mortality rates through the past decade, in comparison to the Healthy People 2010 Objective, reveals that white neonates achieved the goal in the year 2000 (Figure 107). It is unknown if the white neonatal mortality rate will remain below the goal. Blacks have the highest rate of neonatal mortality, while whites have the lowest. In general, the neonatal mortality rates for Nashville are twice as high as the 2010 objective; the black neonatal mortality rate is nearly 4 times higher than the objective.

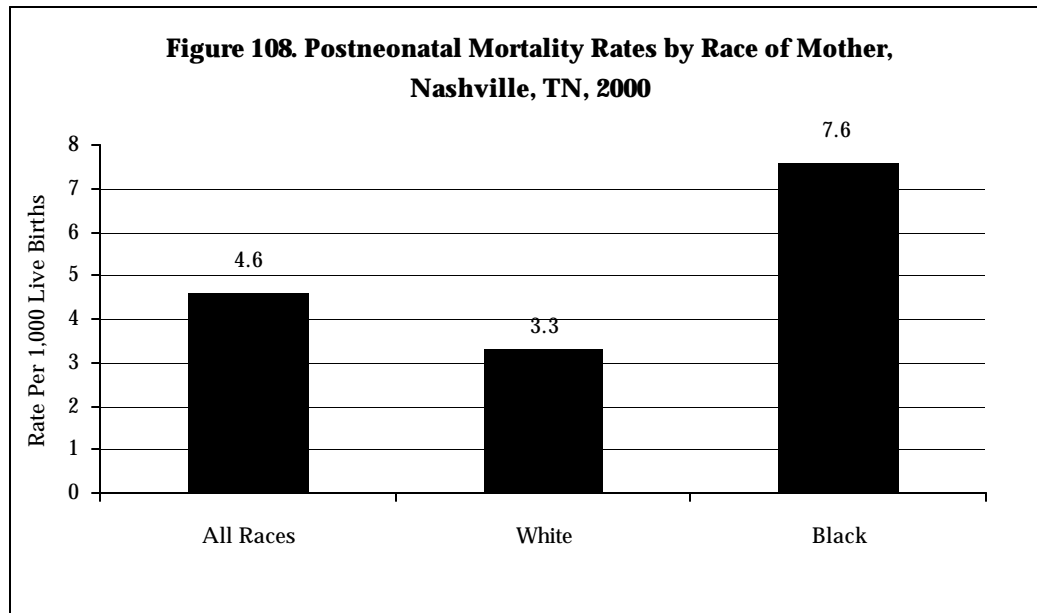
Figure 107. Neonatal Mortality Rates by Race of Mother Compared to the Healthy People 2010 Objective, Nashville TN, 1990-2000



Black postneonates are approximately twice as likely to die than white postneonates.

Postneonatal Mortality

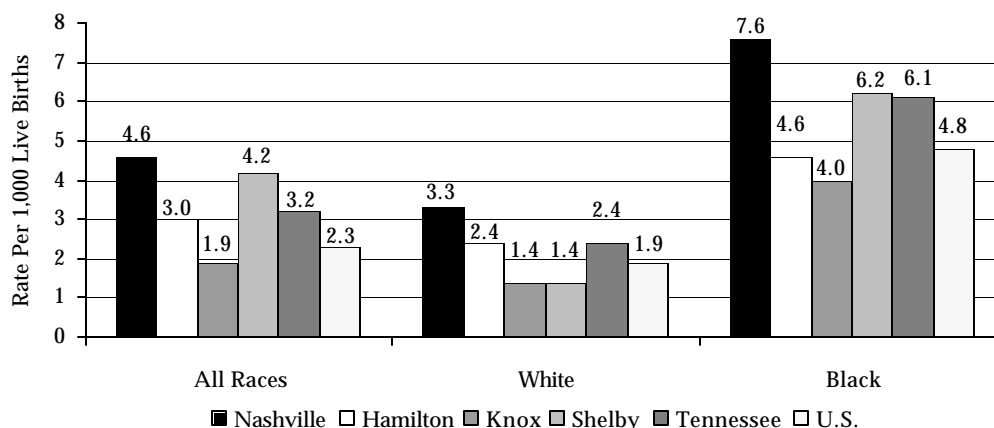
Postneonatal mortality is defined as deaths occurring to children between 28 and 364 days old. For all races combined, Nashville had a postneonatal mortality rate of 4.6 deaths per 1,000 live births in the year 2000. Once again, a disparity between whites and blacks is evident. White postneonates died at the rate of 3.3 per 1,000 live births during 2000, while black postneonates died at the rate of 7.6 per 1,000 live births. Black postneonates are approximately twice as likely to die than white postneonates (Figure 108).



Comparing the postneonatal mortality rates in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S., yields some important observations (Figure 109). All rates discussed are per 1,000 live births. Overall, Nashville has the highest postneonatal mortality rate (4.6), followed closely by Shelby County (4.2). The postneonatal mortality rate in Hamilton County (3.0) is higher than that of the U.S. (2.3), but lower than the Tennessee rate (3.2). Knox County has the lowest postneonatal mortality rate of all areas compared (1.9).

Examining the differences in postneonatal mortality rates by race reveals a large disparity between whites and blacks. This disparity is evident in all of the areas under comparison. Nashville has the highest postneonatal mortality rate for whites (3.3), followed by Hamilton County and Tennessee (2.4). Knox and Shelby Counties have the lowest postneonatal mortality rates for whites (1.4). For blacks, Nashville has the highest postneonatal mortality rate (7.6) followed by Shelby County (6.2), and Tennessee (6.1). Knox County has the lowest black postneonatal mortality rate of all the areas compared (4.0).

Figure 109. Postneonatal Mortality Rates Per 1,000 Live Births, by Race of Mother, Tennessee and Selected Counties, 2000, and the U.S., 1999

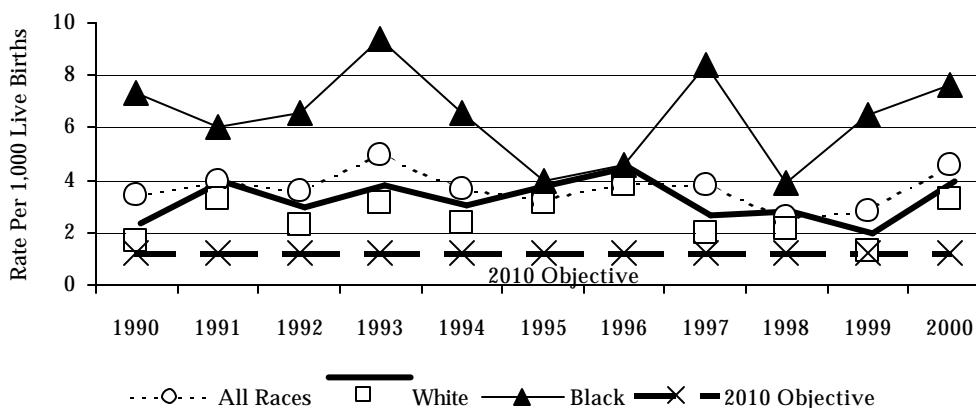


Overall, postneonatal mortality in Nashville is approximately 4 times higher than the objective in 2000.

The Healthy People 2010 Objective is to reduce the postneonatal mortality rate to 1.2 deaths per 1,000 live births. Examining postneonatal mortality rates through the past decade in comparison to the Healthy People 2010 Objective reveals that no group in Nashville has met this goal (Figure 110). Overall, postneonatal mortality in Nashville is approximately 4 times higher than the objective in 2000. The rate for whites is nearly 3 times higher than the objective, and the rate for blacks is approximately 6 times higher than the 2010 objective during the year 2000.

The trend for postneonatal deaths is similar to the trend for infant mortality. The relative ranking indicates that black postneonates are more likely to die than white neonates, and whites consistently have the lowest postneonatal mortality rates in Nashville. Since 1999, the postneonatal mortality rate has been increasing for all groups.

Figure 110. Postneonatal Mortality Rates by Race of Mother, Compared to the Healthy People 2010 Objective, Nashville, TN, 1990-2000



Leading Causes of Neonatal Mortality (Aged 0 to 27 Days)

In Nashville during the year 2000, the primary cause of death for neonates, children aged 0-27 days, was disorders related to short gestation and low birth weight, not elsewhere classified. As shown in Table 20, sixteen neonates died from this cause of death. The second leading cause of death in 2000 was respiratory distress of the newborn with 5 deaths. Low birth weight and prematurity accounted for 33%, or one-third, of all neonatal deaths.

Table 20. Leading Causes of Neonatal Mortality (Infants Aged 0 to 27 Days), Nashville, TN, 2000.

Rank	Cause of Death	Deaths
1	Disorders related to short gestation and low birth weight, not elsewhere classified	16
2	Respiratory distress of newborn	5
3	Bacterial sepsis of newborn	3
3	Neonatal hemorrhage	3
4	Congenital malformations of heart	2
4	Other congenital malformations of nervous system	2
4	Newborn affect by chorioamnionitis*	2
4	Interstitial emphysema and related conditions originating in the perinatal period	2

*Chorioamnionitis is defined by Steadman's Medical Dictionary (25th edition) as an infection involving the fetal membranes and amniotic fluid.

Data Source: Tennessee Department of Health

Infant and fetal mortality rates in Nashville have not improved over the past 10 years.

Leading Causes of Postneonatal Mortality in Infants (Aged 28 to 364 Days)

As shown in Table 21, the leading cause of death for infants aged 28 to 364 days in 2000 was Sudden Infant Death Syndrome, commonly referred to as SIDS. SIDS is defined as "the sudden death of an infant under 1 year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of clinical history".⁴ Although a diagnosis of exclusion, SIDS accounted for 24% of all postneonatal deaths in Nashville in the year 2000. The second leading causes of death for this age group were congenital malformations of the heart and other and unspecified diseases of the respiratory system, each with 4 deaths.

Discussion

Infant and fetal mortality rates in Nashville did not improve between 1990 and 2000. The fetal mortality rate of 5.4 deaths per 1,000 live births plus fetal deaths in 2000 was 24% higher than the Healthy People 2010 objective of 4.1 deaths per 1,000 live births plus fetal deaths. Nashville's infant mortality rate of 10.0 deaths per 1,000 live births was 55% higher than the Healthy People 2010 objective of 4.5 deaths per 1,000 live births. Additionally, Nashville's infant mortality rate was higher than the rates for Tennessee and the U.S.

Table 21. Leading Causes of Postneonatal Mortality (Infants Aged 28 to 364 Days), Nashville, TN, 2000

Rank	Cause of Death	Deaths
1	Sudden Infant Death Syndrome (SIDS)	10
2	Congenital malformations of heart	4
2	Other and unspecified diseases of respiratory system	4
3	Septicemia	3
4	Pneumonia	2
4	Chronic respiratory disease originating in the perinatal period	2
4	Accidental suffocation and strangulation in bed	2

Data source: Tennessee Department of Health

Infant and fetal mortality rates among blacks are increasing, although the rates among whites have demonstrated little variability for the past ten years, resulting in an increased disparity between blacks and whites. The black fetal mortality rate of 9.7 deaths per 1,000 live births plus fetal deaths is 203% higher than the white rate of 3.2. The black infant mortality rate of 19.9 deaths per 1,000 live births is 255% higher than the white rate of 5.6. Nashville's black infant mortality rate is higher than the rates for Tennessee and the U.S.

The leading cause of death differs according to the age of the child at death. For instance, the leading cause of death among neonates, children aged 0 - 27 days, is disorders related to low birth weight and prematurity. Children aged 28 - 364 days, postneonates, predominately die from SIDS.

MPHD addresses infant mortality and its underlying causes through a variety of services and programs. Through the Back to Sleep Campaign, MPHD provides education on safe sleeping environments to infants in order to prevent SIDS. The Car Safety program provides education and low cost child restraints to reduce the risk of death for infants riding in a vehicle. The Healthy Start Home Visiting Program and the Help Us Grow (HUG) program address child abuse and neglect, as well as other health issues through in-home education and intensive case management services. For more information on the services offered by MPHD, please visit the website, <http://healthweb.nashville.org>.

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1. Public Health Service. *International Recommendations on Definitions of Live Birth and Fetal Death*. Washington, DC: U.S. Department of Health, Education, and Welfare; 1950
2. Tennessee Department of Health. *Tennessee Vital Statistics*. 1999.
3. Last, JM, ed. *A Dictionary of Epidemiology*. 2nd ed. New York: Oxford University Press; 1998.

MPHD addresses infant mortality and its underlying causes through a variety of services and programs.

Related Indicators

- Teen births
- Prenatal care
- Perinatal and infant mortality
- Preterm birth

3.2.5 Low Birth Weight

Background

Low birth weight is defined as a weight at birth of less than 2,500 grams or 5 pounds 8 ounces. Birth weight has a strong association with both mortality and morbidity. Research indicates a death during the neonatal period is nearly 40 times more likely to occur among low birth weight infants than infants of normal weight.¹ Additionally, children born at low birth weight are at an increased risk of general morbidity and other disorders such as severe mental retardation and neurological problems.¹

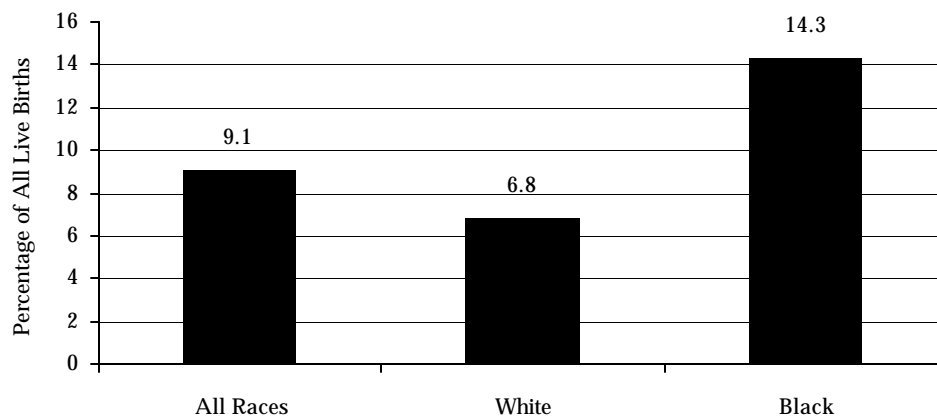
Findings

In Nashville, 9.1% of all live births during the year 2000 weighed less than 2,500 grams. When stratified by race, 6.8% of whites born that year were low birth weight compared to 14.3% of blacks (Figure 111).

Additional Data

Appendices
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Figure 111. Percentage of All Live Births Born Low Birth Weight by Race of Mother, Nashville, TN, 2000



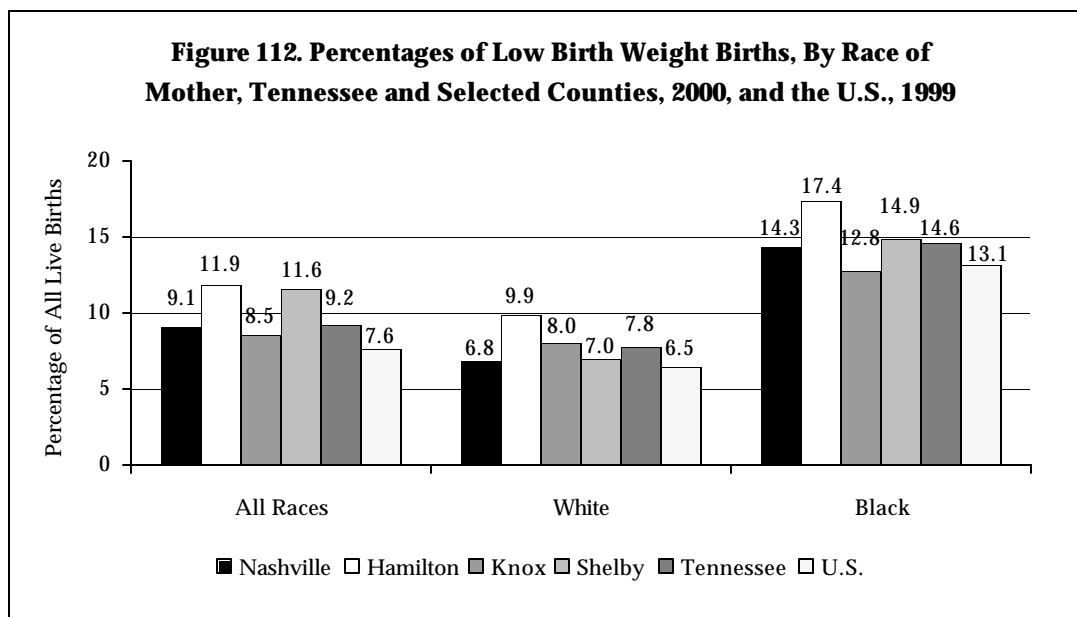
Comparing the percentages of low birth weight births in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S. yields some important observations (Figure 112). All percentages discussed are per all live births. Overall, Hamilton County has the highest percentage of low birth weight (11.9), followed closely by Shelby County (11.6). The percentage of low birth weight babies in Nashville (9.1) is nearly equivalent to that of Tennessee (9.2), but is significantly higher than the U.S. (7.6). Knox County has the lowest percentage of low birth weight births of all areas compared (8.5).

Data Sources

Metro Public Health
Department

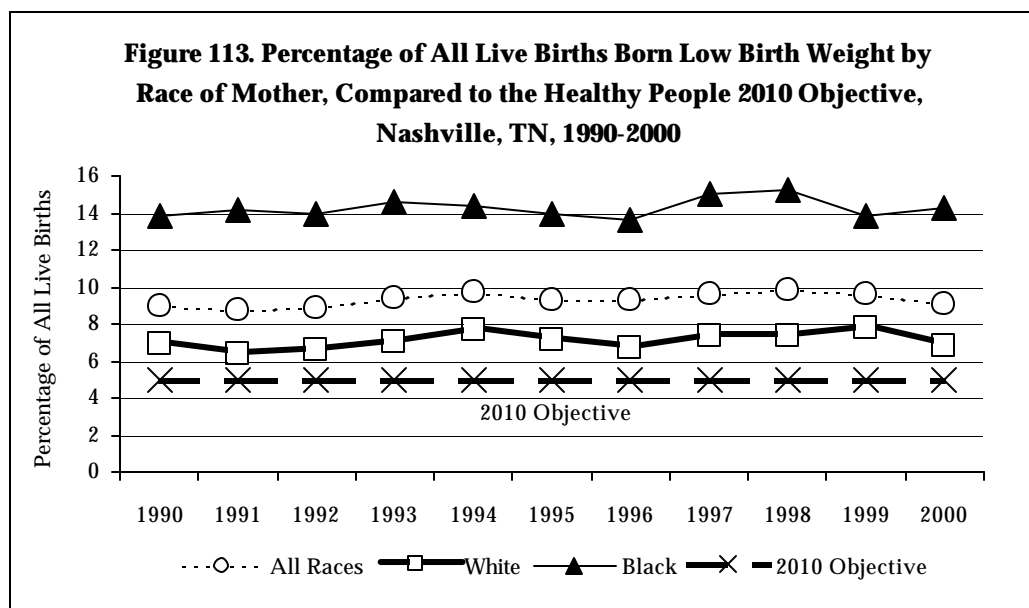
Examining the differences in percentage of low birth weight by race reveals a large disparity between whites and blacks. This disparity is evident in all of the areas under comparison. Hamilton County has the highest percentage of low birth weight babies for whites (9.9). The percentage of low birth weight in Nashville (6.8) is lower than the

percentage for Tennessee (7.8), but higher than the percentage for the U.S. (6.5). All areas in Tennessee under examination have percentages higher than the U.S.. For blacks, Hamilton County has the highest percentage of low birth weight babies (17.4) of all the areas compared. The percentage of black low birth weight babies in Nashville (14.3) is lower than the percentage for Tennessee (14.6), but higher than the U.S. percentage (13.1).



Nationally, there has been little change in the proportion of low birth weight babies over the past few decades.¹ The disparity between whites and blacks has remained fairly steady during the past decade, and Nashville's trend mimics the national trend. The percentage of black babies born less than 2,500 grams hovers between 14 and 15 percent. For whites, the proportion is smaller with only 6 to 8 percent of babies being born low birth weight. Overall, between 8 and 10 percent of births in Nashville each year weigh less than 2,500 grams. The Healthy People 2010 Objective for this indicator is to reduce the percentage of births weighing less than 2,500 grams to 5%. As indicated in Figure 113, there is much work needed in Nashville to achieve that goal by 2010.

Overall, between 8 and 10 percent of births in Nashville each year weigh less than 2,500 grams.



Discussion

As noted in the previous chapter, low birth weight is one of the predominant causes of death for infants less than 28 days old. The percentage of infants born less than 2,500 grams in Nashville during the year 2000 was 9.1%, 45% higher than the Healthy People 2010 objective of 5%. Nashville's percentage of low birth weight babies during the year 2000 is higher than the U.S. percentage, but slightly less than the percentage for Tennessee.

There is a large disparity between blacks and whites for this indicator that has not improved over the past ten years. The black percentage of low birth weight infants in 2000, 14.3%, is 110% higher than the white percentage of 6.8.

In order to reduce Nashville's percentage of low birth weight infants, it will be necessary to address women's health issues both before and during pregnancy. MPHD addresses the issue of maternal smoking, for example, through the SMART MOMS program which offers smoking cessation education and counseling. MPHD also sponsors the Incredible Baby Shower in the fall each year, which informs, educates, and provides opportunities to learn about healthy pregnancies, infant and child development, safety and healthy child issues, parenting issues, and local resources.

Reference:

1. Kiely JL, Brett KM, Yu S, Rowley DL. Low birth weight and intrauterine growth retardation. In: Wilcox, LS, Marks, JS, eds. *From Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children*. U.S. Department of Health and Human Services; 1995.

Low birth weight is one of the predominant causes of death for infants less than 28 days old.

Related Indicators

- Teen births
- Prenatal care
- Perinatal and infant mortality
- Low birth weight

3.2.6 Preterm Birth

Background

Preterm delivery is defined as the termination of pregnancy before the completion of the 37th week of gestation. Preterm birth is a major cause of low birth weight, and combined with low birth weight, is a predominant cause of infant mortality and morbidity.¹ The overall rate of preterm births is gradually increasing nationwide. Research indicates that from 1989 through 1996, there was a 4 percent increase in preterm delivery rates.² This phenomenon seems to be evident in industrialized nations around the world.² Although the exact causes of preterm birth are unknown, risk factors for preterm birth include low socioeconomic status, previous preterm delivery, smoking, and inadequate weight gain during pregnancy.

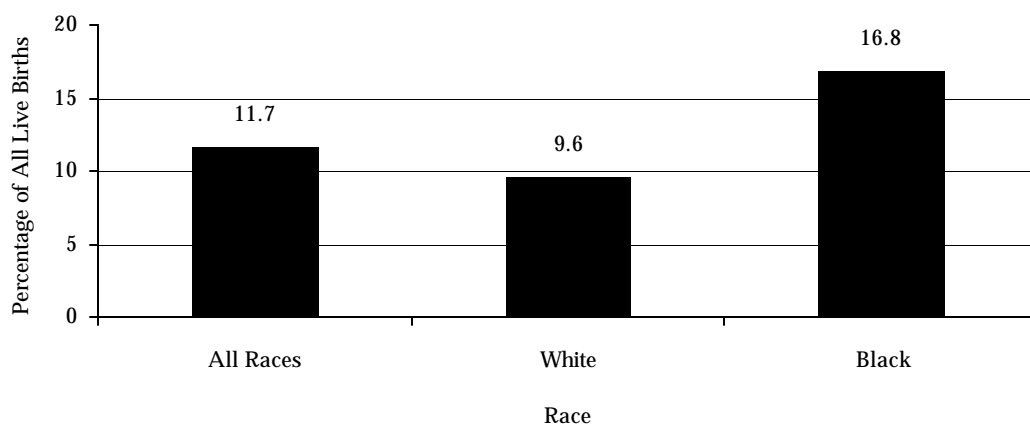
Findings

During the year 2000, 11.7% of babies born in Nashville were premature. When examined by race, 9.6% of white babies born that year were premature compared to 16.8% of black babies (Figure 114).

Additional Data

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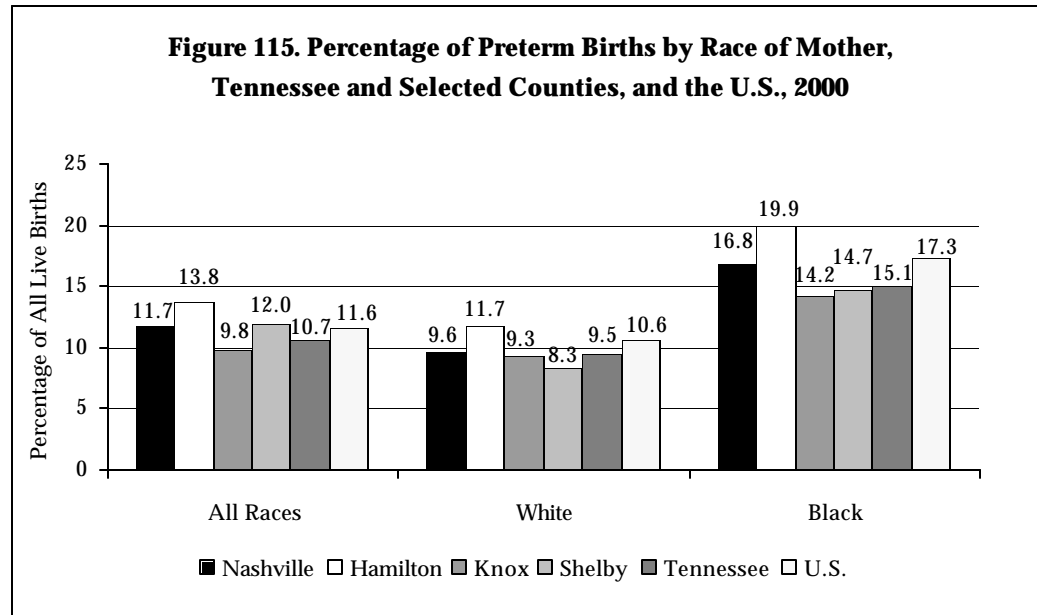
Figure 114. Percent of Preterm Births by Race of Mother, Nashville, TN, 2000



Comparing the percentages of preterm births in Nashville with those of three other metropolitan counties in Tennessee, namely Hamilton, Knox, and Shelby Counties, Tennessee, and the U.S. yields some important observations (Figure 115). All percentages discussed are per all live births. Overall, Hamilton County has the highest percentage of preterm births (13.8). The percentage of preterm births in Nashville (11.7) is nearly equivalent to the U.S. percentage (11.6), but is greater than that of Tennessee (10.7). Knox County (9.8) has the lowest percentage of preterm births of all areas compared.

Data Sources

Metro Public Health
Department



Blacks have the highest percentage of preterm births, and since 1990, that percentage has increased 28%.

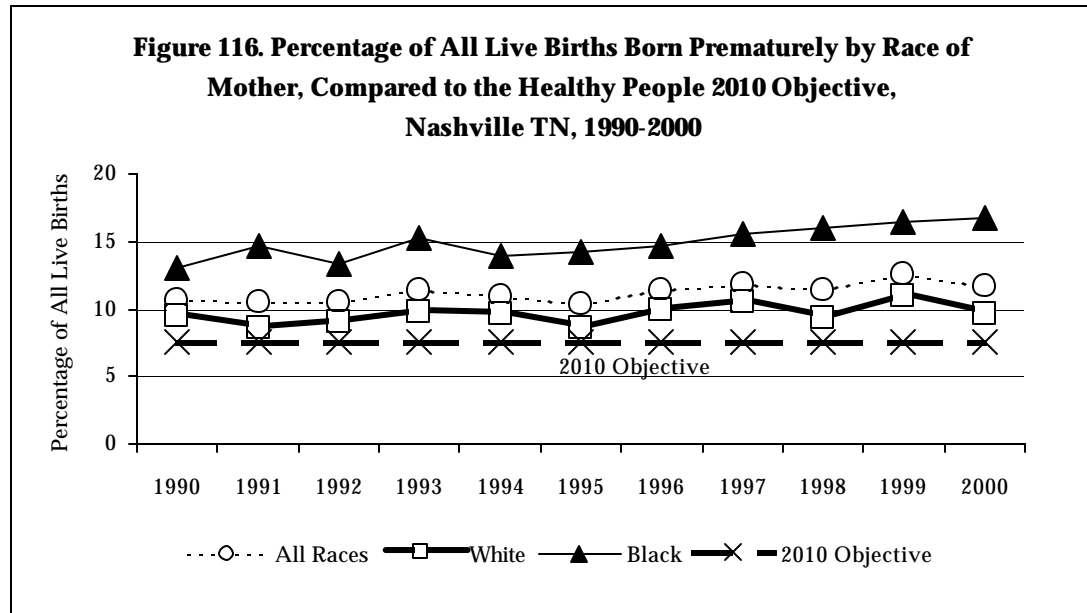
Examining the differences in percentage of preterm birth by race reveals a large disparity between whites and blacks. This disparity is evident in all of the areas under comparison. Hamilton County has the highest percentage of white preterm births (11.7). The percentage of preterm births in Nashville (9.6) is nearly equivalent to the percentage for Tennessee (9.5), and is lower than the percentage in the U.S. (10.6). Shelby County has the lowest percentage of preterm births for whites (8.3) of all the areas compared. For blacks, Hamilton County has the highest percentage of preterm births (19.9) of all the areas compared. The percentage of black preterm births in Nashville (16.8) is lower than the percentage for the U.S. (17.3), but higher than the Tennessee percentage (15.1). Knox County has the lowest percentage of preterm births for blacks (14.2) of all the areas compared.

During the 1990's, in the U.S. the number of preterm deliveries increased among whites by 8%, and the number for blacks decreased by 10%.² As depicted in Figure 115, the trend in Nashville does not mimic the national data. Blacks have the highest percentage of preterm births, and since 1990, that percentage has increased 28%. The percentage of preterm births has also been increasing for whites since 1990, but the degree of increase is considerably less than that for blacks.

The Healthy People 2010 objective is to reduce the percentage of preterm births to 7.6 percent. As is indicated in Figure 116, Nashville falls short of this goal on all accounts. Overall, Nashville exceeds the 2010 goal by 35%. Whites exceed the goal by nearly 21%, and blacks exceed the goal by nearly 55%.

Discussion

Preterm birth, combined with low birth weight, is the leading cause of death of infants less than 28 days old. The percentage of all live birth babies born prematurely in Nashville during 2000 was 11.7%. This percentage is 35% higher than the Healthy People 2010 objective of 7.6%. Nashville's percentage of preterm births in 2000 was higher than the percentage for Tennessee and the U.S.



There is a large disparity between blacks and whites for this indicator that is not improving. The black percentage of preterm births in 2000 (16.8%) was 75% higher than the white percentage of 9.6%.

In order to reduce premature birth in Nashville, it will be necessary to address women's health issues both before and during pregnancy. Many of the programs discussed in Section 3.2.5 also address issues of preterm delivery. Education regarding general health issues coupled with information regarding the signs and symptoms of preterm delivery are included in such programs as Help Us Grow (HUG), Healthy Start, and the Incredible Baby Shower.

References:

1. Blackmore CA, Rowley DL, Kiely JL. Preterm birth. In: Wilcox, LS, Marks, JS, eds. *From Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children*. U.S. Department of Health and Human Services; 1995.
2. Demissie K, Rhoads GG, Ananth CV, Alexander GR, Kramer MS, Kogan MD, Joseph KS. Trends in preterm birth and neonatal mortality among blacks and whites in the United States from 1989 to 1997. *Am J Epidemiol*. 2001;154:307-15.

Preterm birth is a major cause of low birth weight, and combined with low birth weight, is a predominant cause of infant mortality and morbidity. The black percentage of preterm births in 2000 (16.8%) was 75% higher than the white percentage of 9.6%.

Related Indicators

- Prenatal care
- Fertility

3.2.7 Maternal Mortality

Background

A maternal death is “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.”¹ Maternal mortality is measured by the maternal mortality ratio. The maternal mortality ratio is calculated by dividing the number of deaths in a specified time period by the number of live births in the same time period and multiplying the quotient by 100,000.¹

According to the Centers For Disease Control and Prevention (CDC), in the early 1900's the maternal mortality ratio in the United States ranged from 600 to 900 deaths per 100,000 live births.² During the 20th century, improvements in obstetrics and other medical practices, nutrition, and better access to care and education all contributed to a drastic reduction in maternal mortality.² In 1999, the maternal mortality ratio in the United States was 9.9 deaths per 100,000 live births. The maternal mortality ratio in the United States for whites was 6.8 deaths per 100,000 live births; for blacks, it was 25.4 deaths per 100,000 live births. Black mothers were 3.7 times more likely to die from pregnancy related causes, than white mothers. The Healthy People 2010 Objective is to reduce maternal deaths to 3.3 per 100,000 live births.

Table 22. Number of Maternal Deaths and Maternal Mortality Ratios per 100,000 Live Births by Race, Nashville, TN, 1990 - 2000

Year	All Races		White		Black	
	Number	Ratio ¹	Number	Ratio	Number	Ratio
1990	0	0	0	0	0	0
1991	1	11.6	0	0	1	37.2
1992	2	23.7	0	0	2	78.1
1993	1	12	1	18.2	0	0
1994	0	0	0	0	0	0
1995	0	0	0	0	0	0
1996	3	36.4	3	54.5	0	0
1997	0	0	0	0	0	0
1998*	1	11.8	0	0	0	0
1999	3	35.4	1	18.2	2	77.5
2000	0	0	0	0	0	0

*The one death in 1998 was of unknown race

¹The maternal mortality ratio is per 100,000 live births

Total may include events with race other than white or black

Data Sources

Metro Public Health
Department

Findings

Table 22 shows the number of maternal deaths in Nashville, with the corresponding maternal mortality ratio, for each year since 1990. The number of maternal deaths in Nashville is very low, with a maximum of three deaths occurring in 1996 and 1999. Yet, for those years with a maternal death, the maternal mortality ratio is greater than that of the U.S. and the Healthy People 2010 Objective. It is important to note that the disparity in outcomes between whites and blacks is still evident. For example, in 1999, the maternal mortality ratio for blacks was 77.5 deaths per 100,000 live births, a ratio 4.3 times the rate of 18.2 for whites.

Discussion

In 2000, there were no pregnancy-associated deaths in Nashville. Maternal mortality has been very low over the past decade with a total of 11 deaths from 1990 - 2000. It is important to note that maternal deaths represent only the most serious of pregnancy complications. It is estimated that there are 300 - 500 maternal deaths in the U.S. each year, and that for every one of those deaths, there are over 3,600 hospital admissions for complications during pregnancy.¹ Early and adequate prenatal care is the best way to detect and treat pregnancy-related complications before the life of the mother and child is put at risk.

References:

1. Atrash HK, Lawson HW, Ellerbrock TV, Rowley DL, Koonin LM. Pregnancy-related mortality. In: Wilcox, LS, Marks, JS, eds. *From Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children*. U.S. Department of Health and Human Services; 1995.
2. Centers for Disease Control and Prevention. Healthier mothers and babies – 1990-1999. *Morbidity and Mortality Weekly Report*. 1999;48:849-857.

The number of maternal deaths in Nashville is very low, with a maximum of three deaths occurring in 1996 and 1999.

Related Indicators

- Perinatal and infant mortality
- Maternal mortality

3.3 Mortality

Background

Mortality rates are one measurement of the health status of a community. This was recognized early in the history of Nashville when registration of causes of death in the city began in 1874.¹ Since mortality information is routinely reported to the health department via death certificates, this data is frequently used as a major indicator to describe the overall health of Nashville. Mortality rates can reflect advances in medical science and public health or their failings. However, mortality rates alone do not give a complete description of the public's health. Mortality rates do not provide information on the number of sick persons in the community, the type or severity of illnesses which do not cause death, or the quality of life that these persons experience.

Findings

Number of Deaths

In 2000, there were 5,048 resident deaths in Nashville, an increase of 24 deaths from 1999. The racial breakdown for these deaths was 74.2% white, and 24.8% black (Figure 117), which closely mimics the racial break-down of Nashville's population (see Section 2.1.1.3 for more information on racial distribution of the population). Pertaining to gender, 47.7% of the year 2000 deaths were male and 52.3% were female. Grouping deaths by both race and gender, 39% of total deaths occurred in white females, 35% in white males, 13% in black females, and 12% in black males. Of the people who died in 2000, 51.1% were aged 75 or older; 44.4% were between the ages of 25 – 74; and 4.5% were aged 24 or younger. Among blacks, 63.1% of the deaths were of persons less than 75 years of age, and among whites, 43.9% of the deaths were of persons less than 75 years of age.

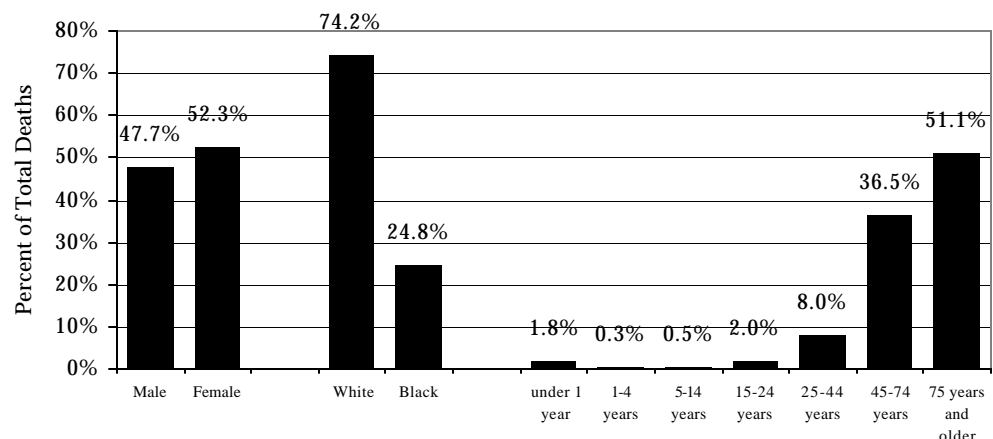
Additional Data

Appendices
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Data Sources

- Metro Public Health Department
- Tennessee Department of Health

Figure 117. Gender, Race, and Age Percent Distribution of Deaths, Nashville, TN, 2000



Crude Death Rate

The crude death rate (CDR) decreased from 947.8 deaths per 100,000 population in 1999 to 885.8 in 2000 (Table 23). This drop of over 60 deaths per 100,000 is not from a decrease in deaths. The decrease in CDR was due to the use of different population numbers for calculations. In 1999, the CDR was calculated using an estimate of Nashville's population for that year. When the 2000 Census count was released, it revealed that Nashville's population was actually much larger than had been estimated in the last 10 years since the 1990 Census. With a much larger denominator for the rate, the CDR decreased in 2000.

Table 23. Number of Deaths and Crude Death Rates, Nashville, TN, 2000

	Deaths	Percent	Crude Death Rate (per 100,000 population)
Total Population	5,048		885.8
<i>Gender Groups</i>			
Male	2,406	47.7%	872.2
Female	2,642	52.3%	898.6
<i>Race Groups</i>			
White	3,747	74.2%	981.4
Black	1,254	24.8%	849.0
<i>Race-Gender Groups</i>			
Black Female	633	0.1%	800.9
Black Male	621	12.0%	904.5
White Female	1,989	39.0%	1,009.7
White Male	1,758	35.0%	951.4
<i>Age Groups</i>			
under 1 year	90	1.8%	1,110.8
1-4 years	14	0.3%	47.1
5-14 years	25	0.5%	36.3
15-24 years	99	2.0%	115.3
25-44 years	402	8.0%	207.6
45-74 years	1,840	36.5%	1,198.6
75 years and older	2,578	51.1%	8,580.2

In 2000, there were 5,048 resident deaths in Nashville with a crude death rate of 885.8 per 100,000 population.

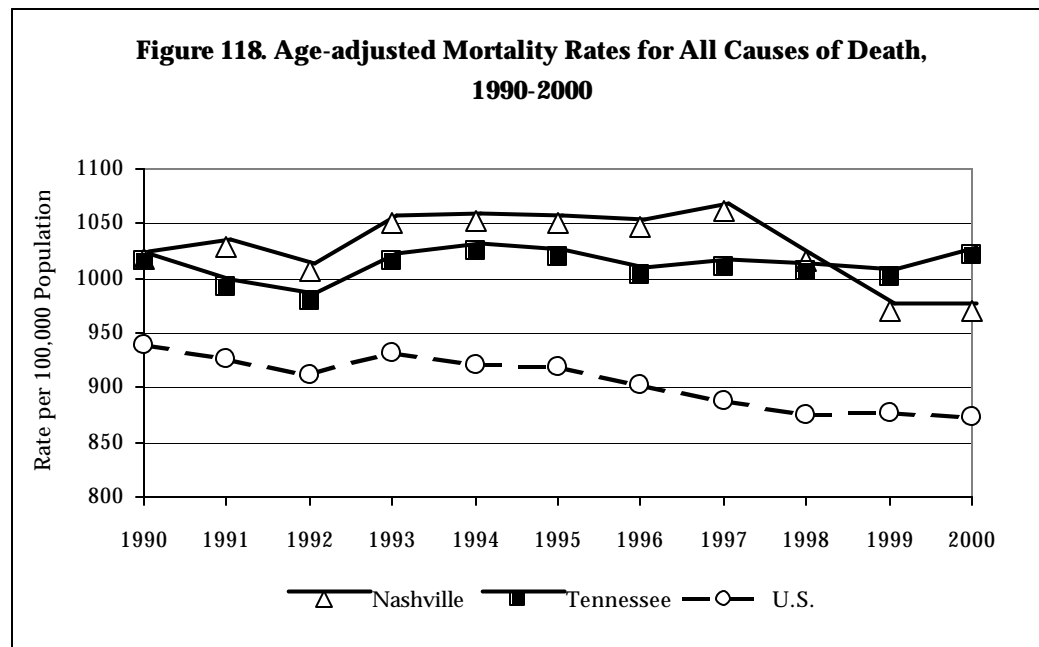
The CDR should not be used to measure or compare differences in death rates between gender and race groups. The following section on age-adjusted rates addresses that issue. However, age-specific CDRs do offer valuable information to evaluate the burden of death in specific age-groups. The CDR for persons under 1 year of age was 1110.8 per 100,000 population in 2000. With more than 50% of the deaths in 2000 occurring in Nashville residents over the age of 75, it is not surprising that the CDR for this age group is nearly 8 times higher than that of any other age group – 8,580.2 per 100,000 population.

Age-adjusted Mortality Rate and Trends

Age-adjusted mortality rates (AMR) are derived from the CDR. Age-adjustment standardizes the death rates to the U.S. 2000 standard population and, subsequently,

removes the differences in age distribution between population subgroups or between different populations. The proper way to compare death rates between blacks, whites, males and females, is to compare their AMRs.

The overall AMR for Nashville in 2000 was 970.1 per 100,000 population. Nashville's rate was lower than the Tennessee overall age-adjusted death rate (1,021.2) but higher than the U.S. rate (872.4) (Figure 118). Nashville's AMR has fluctuated over the last 11 years. In that time the rate had an overall reduction of approximately 5% by 2000. Over the last 11 years, Nashville's AMR has consistently been higher than that of the U.S. From 1990 to 1998, Nashville's AMR was also higher than Tennessee's, but in 1999 the Nashville rate fell below the Tennessee rate and remained there for 2000.



Overall mortality for Nashville has decreased over the last 11 years.

Figure 119 shows that males and blacks have higher death rates (AMRs) than the general Nashville population. This graph also shows that while there were more deaths in women than men, women actually have a lower death rate after removing the differences in the age distribution between the male and female population. The same is true for black and white subgroups. While more whites died in 2000, whites actually have a lower death rate than blacks. As noted earlier, a greater proportion of deaths in blacks occurred in persons under age 75. Deaths at younger ages count more in the AMR, and so, the black death rate is higher than the white. AMRs for females and whites did not change much in the last 11 years. The rate for men was steady for 10 years, but dropped by 12.5% from 1999 to 2000 to a rate of 1196.0 per 100,000 population. The black AMR had no clear trend over the last 11 years, it alternated between increases and decreases. The AMRs for race-gender groups reveal that black males have the highest death rate in Nashville and white females have the lowest (Figure 120).

Discussion

Overall mortality for Nashville has decreased over the last 11 years. If the population is split into race and gender groups, we still see a slight decrease in mortality.

Figure 119. Age-adjusted Mortality Rates by Gender and Race, Nashville, TN, 1990-2000

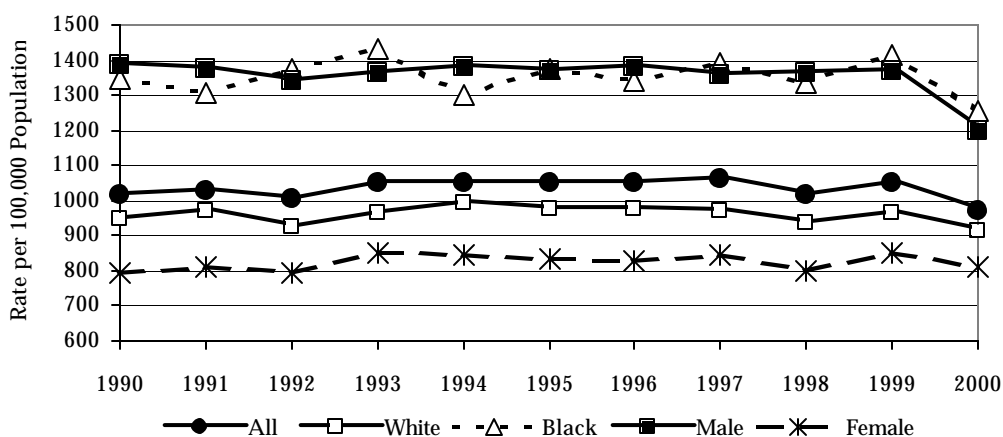
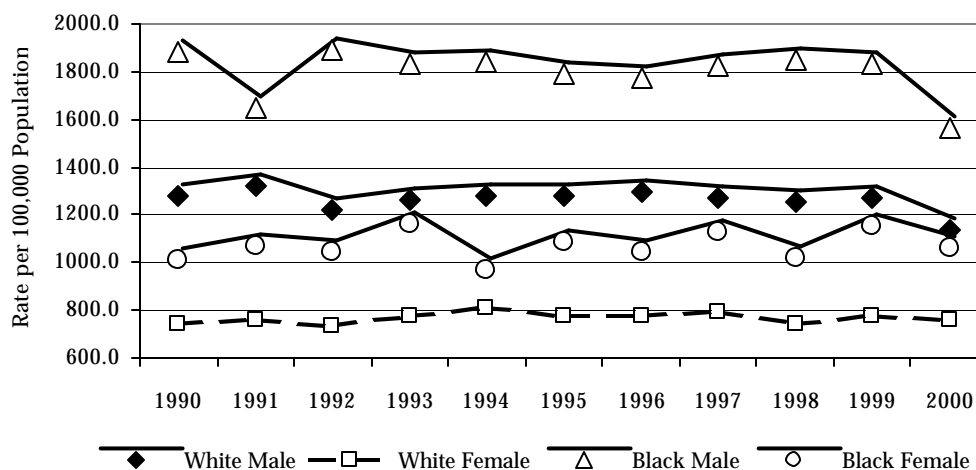


Figure 120. Age-adjusted Mortality Rates for Race-Gender Groups, Nashville, TN, 1990-2000



However, despite the decrease, blacks, males, and especially black males have led Nashville in deaths per population over the last 11 years. Regarding deaths in blacks, many of MPHD's health promotion and chronic disease management programs target health problems that put blacks at higher risk for death – examples are REACH 2010 and the Chronic Disease Intervention Program. Still more should be done to target the health problems that contribute specifically to death in men (both white and black).

Reference:

1. Horner N. Celebrating 150 years of public health in Nashville (1850 - 2000). *Public Health Watch*. Special Edition/April 2000. Vol4/No.2. Nashville, Tennessee: Metropolitan Public Health Department; 2000.

Related Indicators

- Physical activity
- Overweight and obesity
- Tobacco use--smoking
- Environmental tobacco smoke
- Sexual behavior
- Safety belt use
- Bicycle helmet use
- Cancer screening

3.3.1 Leading Causes of Death

Background

Considering deaths by their cause we can learn more specifically what diseases and disorders are prominent in our community. Causes of death are ranked by number of deaths occurring during the year under study to determine the “leading” causes of death. Table 25 contains the top five causes of death in Nashville, dating back to the year 1891. During the early history of Nashville, consumption, now known as tuberculosis, was the leading cause of death. Despite the many advances in medicine and health care access that have occurred over the course of Nashville’s history, the leading causes of death for Nashvillians in 2000—heart disease, cancer, and stroke—have been the leading causes of death since 1934 (for the years presented in Table 25). Heart disease has been among the top five causes of death since 1891.

Findings

Seventy-eight percent of the deaths in Nashville in 2000 were attributable to the 10 conditions listed in Table 24. Heart disease and cancer were responsible for more than half of the deaths. Two changes occurred in the rankings from 1999 to 2000. Deaths due to accidents surpassed deaths from chronic lower respiratory diseases, placing accidents as the fourth leading cause of death in Nashville. Homicide deaths outnumbered suicide deaths in 2000, putting homicide as the 8th leading cause of death.

Additional Data

Appendices
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Table 24. Ten Leading Causes of Death, Number of Deaths, Percent of All Deaths and Age-adjusted Mortality Rates, Nashville, TN, 2000

Rank	Cause	Deaths	Percent	Age-adjusted Mortality Rate†
1	Heart Disease	1,412	28.0%	275.78
2	Cancer	1,123	22.2%	219.02
3	Stroke	406	8.0%	79.83
4	Accidents	261	5.2%	45.81
5	Chronic Lower Respiratory Disease*	220	4.4%	43.38
6	Diabetes Mellitus	161	3.2%	31.19
7	Influenza and Pneumonia	120	2.4%	23.34
8	Alzheimer's Disease	90	1.8%	17.69
8	Homicide	90	1.8%	14.30
9	Suicide	75	1.5%	12.92

* Chronic Lower Respiratory Disease was called Chronic Obstructive Pulmonary Disease previously.

† Age-Adjusted Mortality Rates were calculated using the U.S. 2000 Standard Population. Rates are per 100,000 population.

NOTE: Data from Tennessee Department of Health. Analysis done by Metro Public Health Department.

Data Sources

- Metro Public Health Department
- Tennessee Department of Health

Table 25. Five Leading Causes of Death in Nashville for Selected Years, 1891 - 2000

Year	Cause of Death Rank				
	1	2	3	4	5
1891	Consumption ¹	Pneumonia	Old age	Heart disease	
1892	Consumption	Pneumonia	Heart disease	Infantile Convulsions	Deaths from violence
1895	Consumption	Pneumonia	Old age	Heart disease	Deaths from violence
1897	Consumption	Pneumonia	Heart disease	Convulsions	Old age
1898	Consumption	Pneumonia	Heart disease	Deaths from violence	Senility
1903	Consumption	Pneumonia	Heart disease	Diarrheal illness to children under 5 years of age	Deaths from violence
1904	Consumption	Heart disease	Pneumonia	Diarrheal illness to children under 2 years of age	Deaths from violence
1905	Consumption	Heart disease	Pneumonia	Diarrheal illness to children under 2 years of age	Deaths from violence
1906	Consumption	Heart disease	Pneumonia	Diarrheal illness to children under 2 years of age	Deaths from violence
1907	Consumption	Heart disease	Pneumonia	Diarrheal illness to children under 2 years of age	Nephritis
1908	Consumption	Heart disease	Pneumonia	Diarrheal illness to children under 2 years of age	Nephritis
1909	Consumption	Heart disease	Pneumonia	Diarrheal illness to children under 2 years of age	Nephritis
1934	Heart disease	Tuberculosis	Pneumonia	Cerebral hemorrhage	Cancer
1935	Heart disease	Cerebral hemorrhage	Nephritis	Cancer	Tuberculosis
1937	Heart disease	Cerebral hemorrhage	Nephritis	Cancer	Tuberculosis
1938	Heart disease	Cerebral hemorrhage	Cancer	Congenital malformations	Nephritis
1939	Heart disease	Cerebral hemorrhage	Cancer	Congenital malformations	Tuberculosis
1940	Heart disease	Cerebral hemorrhage	Nephritis	Accidental deaths	Congenital malformations
1941	Heart disease	Cancer	Cerebral hemorrhage	Nephritis	Tuberculosis
1949	Heart disease	Apoplexy ²	Cancer	Accidental deaths	Congenital defects and infancy
1950	Heart disease	Cancer	Apoplexy	Accidental deaths	Pneumonia
1951	Heart disease	Vascular lesions affecting the central nervous system	Malignant neoplasms	Diseases of early infancy	Senility
1952	Heart disease	Cancer	Accidental deaths		
1953	Heart disease	Cancer	Cerebral hemorrhage	Senility	Diseases of early infancy
1954	Heart disease	Cancer	Cerebral hemorrhage	Senility	Diseases of early infancy
1955	Heart disease	Cancer	Cerebral hemorrhage	Ill defined or unknown	Diseases of early infancy
1957	Heart disease	Cerebral hemorrhage	Cancer	Ill defined or unknown	Diseases of early infancy
1958	Heart disease	Cerebral hemorrhage	Cancer	Diseases of early infancy	Pneumonia
1960	Heart disease	Cerebral hemorrhage	Cancer	Diseases of early infancy	Pneumonia
1985	Heart disease	Malignant neoplasms	Cerebrovascular disease	Accidents/Motor vehicle accidents	Chronic obstructive pulmonary disease
1995	Heart disease	Cancer	Stroke	Accidents	Chronic obstructive pulmonary disease
1998	Heart disease	Cancer	Stroke	Pneumonia and influenza	Chronic obstructive pulmonary disease
2000	Heart disease	Cancer	Stroke	Accidents	Chronic Lower Respiratory Diseases ³

¹ Obsolete term for a wasting of the tissues of the body, usually tuberculosis (Stedman's Medical Dictionary, 26th Edition)² Obsolete term for a cerebral stroke, most often due to intracerebral hemorrhage (Stedman's Medical Dictionary, 26th Edition)³ Chronic Lower Respiratory Diseases were previously classified as Chronic Obstructive Pulmonary Diseases.

Eight of Nashville's leading causes of death also ranked in the top 10 for the U.S. (2000 preliminary data) (Table 26). In Nashville, homicide and suicide ranked as the 8th and 9th leading causes of death in 2000, but in the U.S. they ranked 15th and 11th, respectively. Accidents also ranked higher in Nashville than in the U.S. – 4th in Nashville, 5th in the U.S. All other leading causes of death had the same rankings in Nashville and the U.S. Tennessee data for leading causes of death is not yet available for 2000.

Table 26. Leading Causes of Death in the U.S., Preliminary 2000 Data

Rank	Cause of Death
1	Diseases of the heart
2	Malignant neoplasms (cancer)
3	Cerebrovascular diseases (stroke)
4	Chronic lower respiratory diseases
5	Accidents
6	Diabetes Mellitus
7	Influenza and pneumonia
8	Alzheimer's disease
9	Nephritis, nephrotic syndrome, and nephrosis
10	Septicemia

Source: National Vital Statistics Report, Vol. 49, No. 12, October 9, 2001.

Table 27 shows the leading causes of male and female deaths. Grouping by gender does not change the ranking for the top two causes of death – heart disease and cancer – but the rest of the list was affected. Males were more likely than females to die of accidents,

Table 27. Leading Causes of Death by Gender, Nashville, TN, 2000

Rank	Male	Female
1	Heart Disease	Heart Disease
2	Cancer	Cancer
3	Accidents	Stroke
4	Stroke	Chronic Lower Respiratory Diseases
5	Chronic Lower Respiratory Diseases	Accidents
6	Homicide	Diabetes Mellitus
7	Suicide	Influenza and Pneumonia
8	Diabetes Mellitus	Alzheimer's Disease
9	Influenza and Pneumonia	Other Diseases of the Respiratory System
10	HIV Related Disease	Nephritis, Nephrotic Syndrome, and Nephrosia Septicemia

NOTE: Data from Tennessee Department of Health. Analysis done by Metro Public Health Department.

homicide, suicide, and HIV related disease. Females were more likely to die of stroke, diabetes, influenza and pneumonia, and Alzheimer's disease.

The leading causes of death were not the same for white and black populations in Nashville. The top three causes of death were the same – heart disease, cancer, and stroke – and accidents ranked as the fifth leading cause for blacks and the fourth for whites (Figure 121 and Table 28). Whites and blacks also had chronic lower respiratory disease, influenza and pneumonia, and diabetes in common, however, the rankings for these causes differed by race. Deaths due to diabetes were more common in blacks, but deaths from chronic lower respiratory disease and influenza and pneumonia were more common in whites. Additionally, each race group has three unique leading causes of death. For whites, Alzheimer's disease, suicide, and other disorders of the respiratory system ranked as the 8th, 9th, and 10th leading causes of death, respectively. For blacks, homicide, HIV related disease, and perinatal conditions ranked as the 6th, 7th, and 9th leading causes of death, respectively.

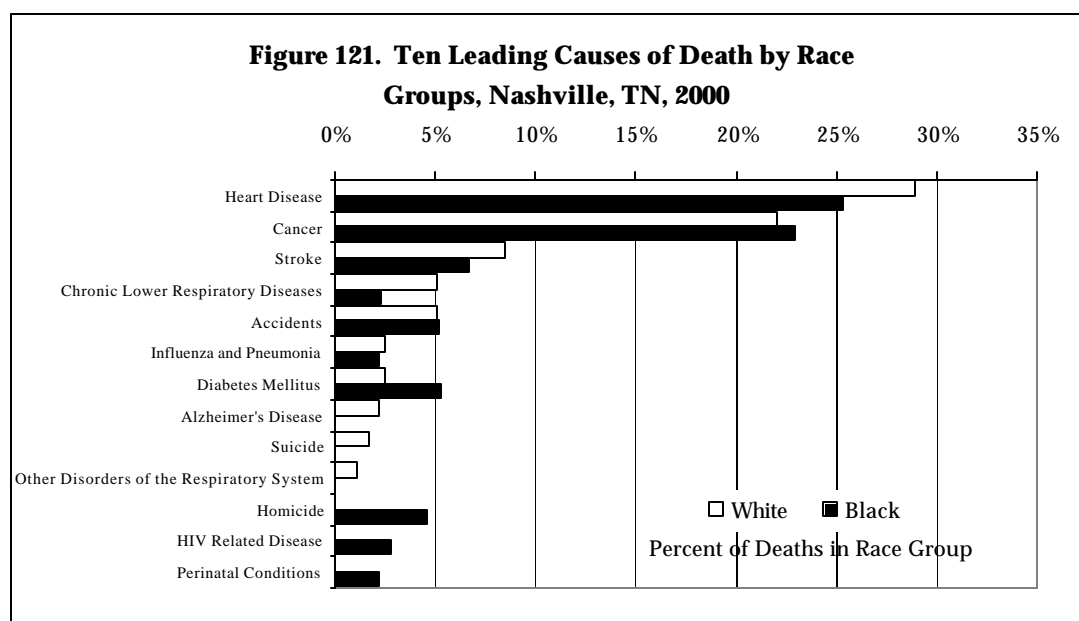


Table 28. Leading Causes of Death by Race, Nashville, TN, 2000

Rank	White	Black
1	Heart Disease	Heart Disease
2	Cancer	Cancer
3	Stroke	Stroke
4	Accidents	Diabetes Mellitus
5	Chronic Lower Respiratory Diseases	Accidents
6	Influenza and Pneumonia	Homicide
7	Diabetes Mellitus	HIV Related Disease
8	Alzheimer's Disease	Chronic Lower Respiratory Diseases
9	Suicide	Perinatal Conditions
10	Other Diseases of the Respiratory System	Influenza and Pneumonia

NOTE: Data from Tennessee Department of Health. Analysis done by Metro Public Health Department.

Table 29 contains the leading causes of death grouped by both race and gender. It reveals that there were some unique leading causes of death in each race-gender group. Deaths due to perinatal conditions occurred predominately in black males. Leading causes of death that were unique to the black females included hypertension and septicemia. Other diseases of the respiratory system and circulatory system were unique to the leading causes of death for white females, and chronic liver disease and cirrhosis were unique to white males. This grouping also shows that many causes of death did not rank the same in each of the race-gender groups. For instance, cancer and not heart disease was the leading cause of death in black males.

Table 29. Leading Causes of Death by Race-Gender Groups, Nashville, TN, 2000

Rank	White Male	Black Male	White Female	Black Female
1	Heart Disease	Cancer	Heart Disease	Heart Disease
2	Cancer	Heart Disease	Cancer	Cancer
3	Accidents	Homicide	Stroke	Stroke
4	Stroke	Accidents	Chronic Lower Respiratory Diseases	Diabetes Mellitus
5	Chronic Lower Respiratory Diseases	Stroke	Accidents	Accidents
6	Suicide	Diabetes Mellitus	Diabetes Mellitus	Hypertension Influenza and Pneumonia
7	Influenza and Pneumonia	HIV Related Diseases	Influenza and Pneumonia	Unclassified Clinical and Laboratory Findings
8	Alzheimer's Disease	Perinatal Conditions	Alzheimer's Disease	Homicide
9	Diabetes Mellitus	Chronic Lower Respiratory Diseases	Other Diseases of the Respiratory System	Chronic Lower Respiratory Diseases Septicemia
10	Chronic Liver Disease and Cirrhosis	Suicide	Other Diseases of the Circulatory System	Nephritis, Nephrotic Syndrome, and Nephrosia

NOTE: Data from Tennessee Department of Health. Analysis done by Metro Public Health Department.

Many causes of death are associated with specific age groups. When the year 2000 deaths were categorized by age groups (Table 30), accidents emerged as the leading cause of death for residents between ages 1 and 44. Because the numbers of deaths were very small in some age groups, data should be interpreted cautiously.

Please see the Appendix for leading cause of death information by planning and council districts.

Table 30. Leading Causes of Death by Age Group, Nashville, TN, 2000

Rank	< 1 Year (deaths)	1-4 Years (deaths)	5-14 Years (deaths)	15-24 Years (deaths)	25-44 Years (deaths)	45-64 Years (deaths)	65+ Years (deaths)
1	Perinatal Conditions (39)	Accidents (5)	Accidents (12)	Accidents (40)	Accidents (93)	Cancer (311)	Heart Disease (1111)
2	Congenital Anomalies (14)	Cancer (3)	Congenital Anomalies Heart Disease (2) Cancer (2)	Homicide (29)	Heart Disease (46) Homicide (46)	Heart Disease (246)	Cancer (765)
3	Unclassified Clinical and Laboratory Findings (12)			Suicide (11)	HIV Related Disease (41)	Accidents (42)	Stroke (360)
4	Accidents (4) Heart Disease (4) Other Diseases of the Respiratory System (4)			Heart Disease (3)	Cancer (40)	Stroke (40) Diabetes Mellitus (40)	Chronic Lower Respiratory Diseases (181)
5	Septicemia (3)			Other Diseases of the Respiratory System (2) Unclassified Clinical and Laboratory	Suicide (31)	Chronic Lower Respiratory Diseases (34)	Diabetes Mellitus (111)
6	Influenza & Pneumonia (2)				Diabetes Mellitus (9)	Chronic Liver Disease and Cirrhosis (26)	Influenza & Pneumonia (106)
7					Chronic Liver Disease and Cirrhosis (8)	Suicide (22)	Alzheimer's Disease (87)
8					Unclassified Clinical and Laboratory Findings (7)	HIV Related Disease (19)	Accidents (64)
9					Stroke (5) Influenza & Pneumonia (5)	Nephrotic Syndrome and Nephrosia (14)	Other Diseases of the Circulatory System (37)
10						Homicide (10)	Nephritis, Nephrotic Syndrome, and Nephrosia (36)

NOTE: Data from Tennessee Department of Health. Analysis done by Metro Public Health Department.

Discussion

Heart disease, cancer, and stroke have been the top three causes of death in Nashville for many years. MPHD has numerous health promotion and disease prevention programs targeted at reducing the burden of these diseases in our community, and subsequently the number of deaths. For heart disease, community coalitions facilitated by the MPHD like the Tobacco Control Initiative and Walk Nashville target behaviors to reduce risk for disease. The Chronic Disease Intervention Program is an example of MPHD's work to fight the consequences of diseases like diabetes. The high number of deaths from accidents and homicide points to the need for us to address violence as a public health issue. MPHD has begun to do this with its Unintentional Injury Prevention program and Violence Prevention Initiative.

Heart disease, cancer, and stroke have been the top three causes of death in Nashville for many years.

Related Indicators

- Physical activity
- Overweight and obesity
- Tobacco use--smoking
- Environmental tobacco smoke
- Sexual behavior
- Safety belt use
- Bicycle helmet use
- Cancer screening

Additional Data

Appendices
pages D-64 - D-72

Data Sources

- Metro Public Health Department
- Tennessee Department of Health

3.3.2 Years of Potential Life Lost

Background

The death of a person at a young age might be interpreted as that person's life being cut short. Years of potential life lost (YPLL) is a measure of premature death for persons under 75 years of age.^{1,2} Deaths prior to age 75 are considered premature because life expectancy in the U.S. is approximately 75 years. The most current estimate of life expectancy in the U.S. is 76.7 years for persons born in 1998.³ The YPLL value for each decedent under age 75 is simply the difference between their age at death and the target of 75 years (YPLL=75-age at death). YPLL can be calculated for all deaths or for specific causes of death.

Ranking causes of death by their cumulative YPLL creates a list somewhat different from the leading causes of death in section 3.3.1 of this report. Deaths from cancer resulted in the largest number of YPLL for any cause of death (Table 32). As would be expected, causes of death more prevalent in younger age groups ranked high for YPLL. For example, accidents, homicide, and perinatal conditions were all in the top 10 causes of YPLL. Perinatal conditions caused more YPLL in blacks than whites. Chronic lower respiratory disease was a unique leading cause of YPLL in whites, while congenital anomalies and diabetes mellitus were unique in blacks.

Findings

Nashville's YPLL rates per population were higher in general than those of the U.S. (Table 31). The Nashville rates ranged from only slightly higher to more than double the U.S. rates. Nashville's rate for YPLL from cancer was only 4% higher than the U.S.

Table 31. Leading Causes of Years of Potential Life Lost, Age-adjusted Rate per 100,000 Population*, Nashville, TN 2000 and U.S. 1998

Cause	Age-adjusted YPLL per 100,000 population	
	Nashville, TN 2000	U.S. 1998
Cancer	1,816.2	1,746.90
Heart Disease	1,540.1	1,365.30
Accidents	1,427.9	1,047.10
Homicide	614.6	298.2
Perinatal Conditions	518.2	NA ¹
Suicide	380.6	363.3
HIV Related Diseases	357.9	175.4
Congenital Abnormalities	254.2	NA
Diabetes Mellitus	254.7	176.8
Unclassified Clinical and Laboratory Findings	238.6	NA

* Adjusted to the U.S. 2000 standard population

¹ NA indicated the rate was not available.

Table 32. Leading Causes of Death Ranked by Years of Potential Life Lost, by Race, Nashville, TN, 2000

All			White			Black		
Rank	Cause	YPLL	Rank	Cause	YPLL	Rank	Cause	YPLL
	All Causes	54,163.00		All Causes	31,857.00		All Causes	21,407.50
1	Cancer	9,771.00	1	Cancer	6,613.00	1	Cancer	3,044.00
2	Heart Disease	8,504.50	2	Accidents	5,843.50	2	Heart Disease	2,847.00
3	Accidents	8,445.00	3	Heart Disease	5,505.00	3	Homicide	2,589.00
4	Homicide	3,930.50	4	Suicide	1,812.50	4	Accidents	2,503.50
5	Perinatal Conditions	3,028.50	5	Homicide	1,270.50	5	Perinatal Conditions	2,086.00
6	Suicide	2,344.00	6	HIV Related Diseases	958.50	6	HIV Related Disease	1,224.50
7	HIV Related Diseases	2,183.00	7	Unclassified Clinical and Laboratory Findings	956.50	7	Congenital Abnormalities	733.00
9	Congenital Abnormalities	1,458.50	8	Chronic Lower Respiratory Diseases	884.50	8	Diabetes Mellitus	641.00
8	Unclassified Clinical and Laboratory Findings	1,422.00	9	Perinatal Conditions	793.50	9	Stroke	550.50
10	Diabetes Mellitus	1,404.00	10	Stroke	756.50	10	Suicide	470.50

Data Source: Tennessee Department of Health, October 8, 2001, April 17, 2002.

rate and our suicide rate was only 5% higher than the U.S. The YPLL rate from diabetes was 44% higher in Nashville than the U.S. The largest differences in rates were for HIV-related disease and homicide. The Nashville YPLL rates for these causes of death were double the rates in the U.S.

When considering YPLL by gender, we find that accidents and heart disease caused the greatest YPLL in males (Table 33). Cancer caused the greatest YPLL in females. Suicide was a leading cause of YPLL in males, but did not rank in the top 10 for females. Congenital anomalies and chronic lower respiratory diseases were leading causes of YPLL in females but not males.

Table 33. Leading Causes of Death Ranked by Years of Potential Life Lost, by Gender, Nashville, TN, 2000

Male			Female		
Rank	Cause	YPLL	Rank	Cause	YPLL
	All Causes	34,172		All Causes	19,991
1	Accidents	5,713.50	1	Cancer	4,560.50
2	Heart Disease	5,435	2	Heart Disease	3,010
3	Cancer	5,210.50	3	Accidents	2,791
4	Homicide	3,080.50	4	Perinatal Conditions	894
5	Perinatal Conditions	2,134.50	5	Congenital Anomalies	893.5
6	Suicide	2,043.50	6	Homicide	850
7	HIV Related Disease	1,634	7	Diabetes Mellitus	648.5
8	Unclassified Clinical and Laboratory Findings	917.5	8	Stroke	625
9	Diabetes Mellitus	755.5	9	HIV Related Disease	549
10	Stroke	697.5	10	Chronic Lower Respiratory Disease	512

Data Source: Tennessee Department of Health, October 8, 2001, April 17, 2002.

Grouping leading causes of YPLL for 2000 deaths by race and gender categories, we see that the top rankings in each group include cancer, heart disease, and accidents (Table 34). While these three causes claimed a great proportion of YPLL in black males, homicide topped the list, accounting for 15% of the total YPLL. Chronic liver disease and cirrhosis were a leading cause of YPLL in white males, but not in any other group. Similarly, chronic lower respiratory diseases were a unique leading cause of YPLL in white females, and septicemia was unique to black females.

YPLL calculations by planning district and council district are in the Appendix.

Table 34. Leading Causes of Death Ranked by Years of Potential Life Lost, by Race and Gender, Nashville, TN, 2000

Rank	White Male		White Female		Black Male		Black Female	
	Cause	YPLL	Cause	YPLL	Cause	YPLL	Cause	YPLL
	All Causes	20,381.50	All Causes	11,475.50	All Causes	13,185.00	All Causes	8,222.50
1	Accidents	3,896.00	Cancer	3,156.50	Homicide	2,037.50	Cancer	1,352.00
2	Heart Disease	3,754.00	Accidents	1,947.50	Cancer	1,692.00	Heart Disease	1,212.50
3	Cancer	3,456.50	Heart Disease	1,751.00	Accidents	1,660.00	Accidents	843.50
4	Suicide	1,567.50	Congenital Anomalies	485.50	Heart Disease	1,634.50	Perinatal Conditions	596.00
5	Homicide	1,017.50	Chronic Lower Respiratory Disease	470.00	Perinatal Conditions	1,490.00	Homicide	551.50
6	HIV Related Disease	755.50	Unclassified Clinical and Laboratory Findings	443.50	HIV Related Disease	878.50	Congenital Anomalies	408.00
7	Perinatal Conditions	644.50	Stroke	335.00	Suicide	415.00	HIV Related Disease	346.00
8	Unclassified Clinical and Laboratory Findings	513.00	Diabetes Mellitus	332.00	Unclassified Clinical and Laboratory Findings	359.00	Diabetes Mellitus	316.50
9	Chronic Liver Disease and Cirrhosis	452.00	Homicide	253.00	Congenital Anomalies	325.00	Septicemia	310.00
10	Stroke	421.50	Suicide	245.00	Diabetes Mellitus	324.50	Stroke	290.00

Data Source: Tennessee Department of Health, October 8, 2001, April 17, 2002.

Discussion

While general mortality statistics tell us what health problems contribute most to deaths in Nashville, they are dominated by deaths of the elderly and give little attention to deaths of younger persons. YPLL is useful in assessing the impact of deaths in younger persons, or premature mortality. Cancer, heart disease, accidents, and homicide contribute the most to Nashvillians' premature mortality. Cancer and heart disease contribute a great amount because of the large *number* of deaths attributable to these causes, while accidents and homicide are responsible for a large number of lost years because the majority of Nashvillians who lose their life in accidents or from homicide are relatively young (between the ages of 1 and 44). YPLL also emphasizes the need for reducing deaths from accidents in males. Years lost due to accidental deaths surpass years lost due to heart disease in this subgroup of the population.

References:

1. Centers for Disease Control and Prevention. Premature mortality in the United States: public health issues in the use of years of potential life lost. *Morbidity and Mortality Weekly Report*. 1986;35(2S):1-11.
2. National Center for Health Statistics. *Health, United States 1996-1997 and Injury Chartbook*. Hyattsville, MD: Centers for Disease Control and Prevention; 1997.
3. Anderson, RN. United States life tables, 1998. *National Vital Statistics Reports*. Vol. 48 no. 18. Hyattsville, Maryland: National Center for Health Statistics; 2001.

YPLL is useful in assessing the impact of deaths in younger persons, or premature mortality. Cancer, heart disease, accidents, and homicide contribute the most to Nashvillians' premature mortality.

Related Indicators

- Food protection in restaurants and retail food stores
- Drinking water

3.4 Morbidity Associated with Notifiable Diseases or Conditions

Background

A notifiable disease/condition is one for which regular, frequent, and timely information regarding individual cases is considered necessary for the prevention and control of the disease. The Centers for Disease Control and Prevention (CDC) in collaboration with the Council of State and Territorial Epidemiologists determine which diseases are notifiable at the national level. The list is revised periodically to include emerging diseases and to eliminate diseases whose incidence is declining.¹ In Tennessee, the Tennessee Department of Health is given responsibility for the formulation of regulations for the control of communicable diseases under provisions of the Tennessee Code Annotated, Sections 49-6, 68-5, 68-8, 68-9, and 68-10. *Regulations Governing Communicable Diseases in Tennessee* provides the guidelines for notifiable disease/condition reporting in the state.² Currently, 56 diseases and conditions are reportable to the local health department by all hospitals, physicians, laboratories, and other persons knowing of or suspecting a case.

Surveillance for notifiable diseases has always been a priority for assessing the health of a community. Timely intervention by public health and other health care providers prevents secondary spread of diseases. Epidemiological information pertaining to notifiable diseases assists those in policy-making positions to determine public health priorities and to plan, implement, and evaluate the effectiveness of programs.

Although antibiotics, vaccines, and public health efforts significantly impacted the prevalence of diseases such as polio, measles, and tuberculosis, they were never completely eradicated. New diseases such as hantavirus, Ebola virus, and “mad cow disease” (a new variant of Creutzfeldt-Jakob disease) continue to emerge. Established conditions have re-emerged or modified to become new threats, i.e., AIDS became a global public health concern, and many cases of tuberculosis are now resistant to the antibiotics that had previously treated the disease effectively. In addition, some microbes, such as staphylococcus bacteria, have begun to exhibit reduced susceptibility to Vancomycin, the antibiotic of last resort.

Adding to the importance of notifiable disease/condition surveillance, new research has revealed that the pathogens that cause infectious disease might also contribute to chronic diseases. Infection with *Helicobacter pylori* is now associated with stomach ulcers. Chronic infection with the hepatitis B and C viruses can lead to liver cancer.³ Lyme disease, a tick-borne disease, can cause arthritis and other neurologic disease.³ Other research is investigating a link between heart disease and the bacterium *Chlamydia pneumoniae*.³

Today an increasing urgency surrounds notifiable disease surveillance since infectious agents have been used as threats by terrorists. The suffering, death, and economic costs of infectious disease are now magnified by the idea that some of these agents, so hard fought to eliminate as a threat to mankind, may now intentionally be used by mankind upon itself.

Although notifiable disease/condition data is useful for analyzing trends and determining relative disease burdens, the data may be limited by the fact that not all cases of disease are reported to health officials. The degree of completeness of data

Data Sources

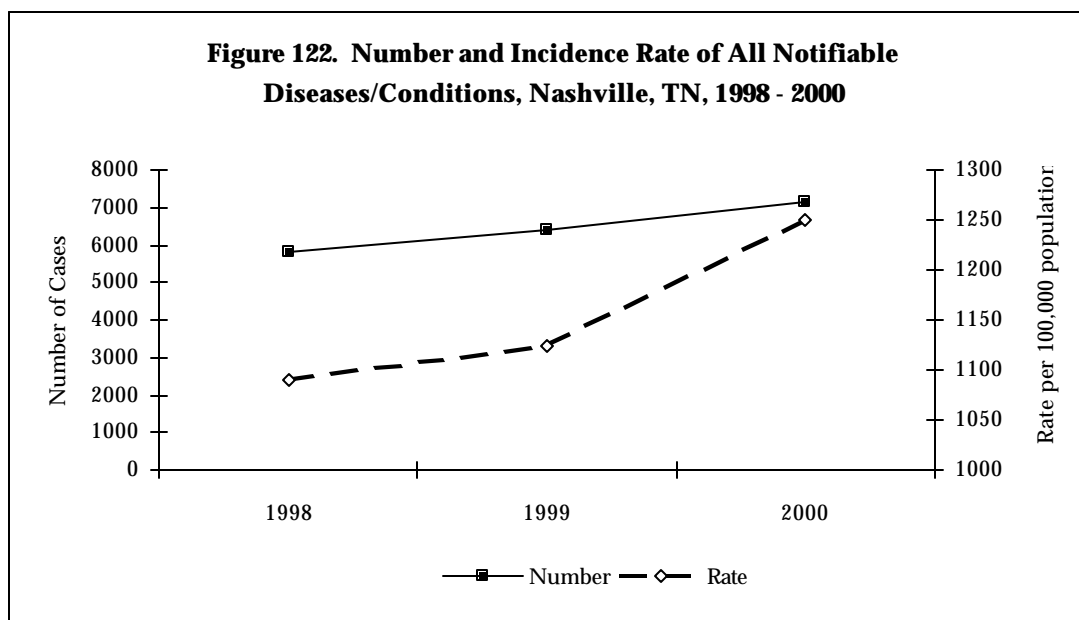
- Metro Public Health Department
- Tennessee Department of Health

reporting may be influenced by the severity of the illness with diseases causing severe physical illness and diagnosed by a clinician being most likely to be reported. Persons with a notifiable disease/condition who experience mild symptoms may not seek medical care. Other factors influencing the completeness of data reporting include: diagnostic facilities available; control measures in effect; public awareness of a specific disease; resources/priorities of the local health officials responsible for disease control; changes in the case definitions for public health surveillance; introduction of new diagnostic tests; and discovery of new disease entities.¹

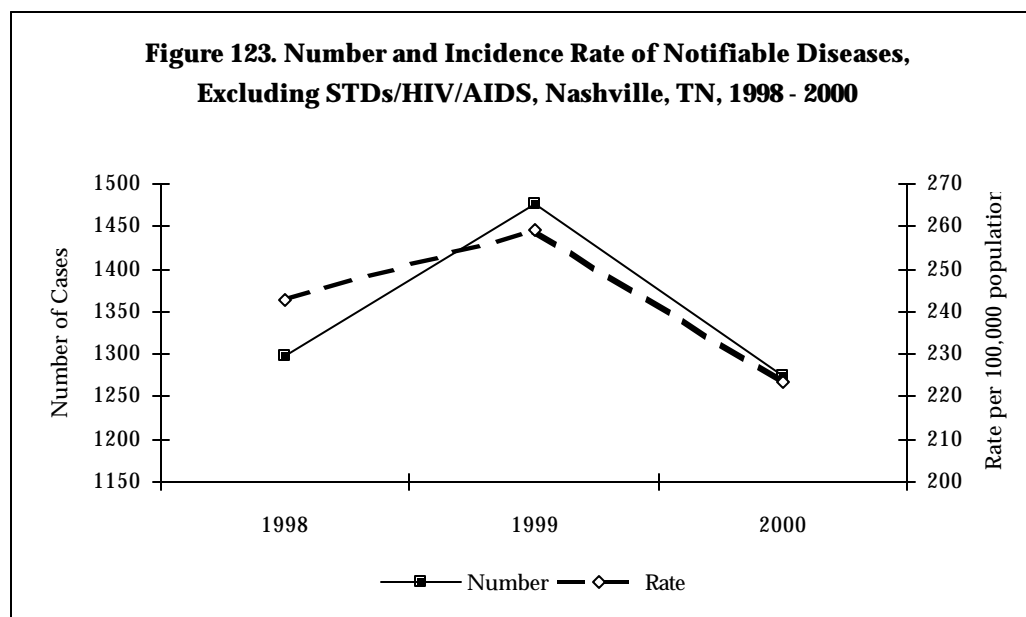
Findings

Trend of Reported Notifiable Diseases/Conditions

From 1998 to 2000, the incidence rate per 100,000 population for reported cases of all notifiable diseases/conditions in Nashville increased from 1,090.1 in 1998 to 1,250.8 in 2000 (Figure 122). Over 19,300 cases of notifiable diseases were reported in the three-year period. (**Note:** The sexually transmitted diseases (STDs) syphilis, gonorrhea, chlamydia, and HIV/AIDS are discussed in Section 3.4.3. Section 3.4.1 will discuss all notifiable diseases/conditions excluding STDs.) Table 35 presents the number of reported cases and incidence rates for the non-STD notifiable diseases for years 1998 through 2000. Over 4,000 cases of non-STD diseases were reported in Nashville during the three years with 1,476 cases reported in 1999. The incidence rate for 1999 was 259.0 per 100,000 population (Figure 123).



From 1998 to 2000, the incidence rate per 100,000 population for reported cases of all notifiable diseases/conditions in Nashville increased from 1,090.1 in 1998 to 1,250.8 in 2000.



Ten Most Frequently Reported Notifiable Diseases/Conditions

The ten most frequently reported notifiable diseases/conditions in Nashville are presented in Table 36. Chlamydia, gonorrhea, and influenza were the three most frequently reported notifiable diseases each year from 1998 through 2000. Syphilis, which ranked 4th in 1999 and 2000, was fifth in 1998 as an outbreak of shigellosis moved that disease into the number four position. Shigellosis remained among the ten most frequently reported diseases in 1999 as the outbreak that began in 1998 continued. HIV/AIDS, tuberculosis, salmonellosis, and Vancomycin resistant enterococci were among the most frequently reported diseases each of the three years. Acute hepatitis A ranked number ten in reported cases in 2000.

Table 37 presents the ten most frequently reported notifiable diseases/conditions in Nashville when STDs and HIV/AIDS are excluded.

References:

1. Centers for Disease Control and Prevention. Summary of notifiable diseases, United States, 1999. *Morbidity and Mortality Weekly Report*. April 6, 2001/ Vol.48/No.53.
2. Tennessee Department of Health and Environment. *Regulations Governing Communicable Diseases in Tennessee*. 1987.
3. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Preventing emerging infectious diseases. a strategy for the 21st century. 1998 [online]. Available at: <http://www.cdc.gov/ncidod/emergplan/planrequest.htm>. Accessed February 13, 2002.

Chlamydia, gonorrhea, and influenza were the three most frequently reported notifiable diseases each year from 1998 to 2000.

Table 35. Number and Incidence of Reported Notifiable Diseases/Conditions, Excluding STDs/HIV/AIDS, Nashville, Tennessee, 1998 - 2000

Disease	1998		1999		2000	
	Number of Cases	Incidence Rate [^]	Number of Cases	Incidence Rate [^]	Number of Cases	Incidence Rate [^]
Anthrax	0	0.0	0	0.0	0	0.0
Botulism	0	0.0	1	0.2	0	0.0
Brucellosis	0	0.0	0	0.0	0	0.0
Campylobacteriosis	16	3.0	34	6.0	40	7.0
Cholera	0	0.0	0	0.0	0	0.0
Cyclospora	0	0.0	0	0.0	0	0.0
Cryptosporidiosis	2	0.4	2	0.4	1	0.2
Diphtheria	0	0.0	0	0.0	0	0.0
Ehrlichiosis	1	0.2	3	0.5	4	0.7
Encephalitis, arboviral						
California/LaCrosse serogroup	0	0.0	0	0.0	0	0.0
Eastern Equine	0	0.0	0	0.0	0	0.0
St. Louis	0	0.0	0	0.0	0	0.0
Western Equine	0	0.0	0	0.0	0	0.0
West Nile-like	0	0.0	0	0.0	0	0.0
<i>Escherichia coli</i> 0157:H7	7	1.3	4	0.7	8	1.4
Giardiasis	23	4.3	28	4.9	23	4.0
Group A Strep Invasive Disease	3	0.6	13	2.3	15	2.6
Group B Strep Invasive Disease	0	0.0	0	0.0	2	0.4
<i>Haemophilus influenzae</i> Invasive Disease	9	1.7	5	0.9	6	1.1
Hantavirus Disease	0	0.0	0	0.0	0	0.0
Hemolytic Uremic Syndrome	0	0.0	0	0.0	0	0.0
Hepatitis A, Acute	44	8.2	50	8.8	43	7.5
Hepatitis B, Acute	45	8.4	22	3.9	38	6.7
Hepatitis B, HBsAg positive pregnant female	2	NA	3	NA	22	NA
Hepatitis C, Acute	4	0.7	22	3.9	18	3.2
Influenza	450	84.3	867	152.1	720	126.3
Legionellosis	0	0.0	1	0.2	0	0.0
Leprosy	0	0.0	0	0.0	0	0.0
Listeriosis	4	0.7	3	0.5	0	0.0
Lyme Disease	5	0.9	7	1.2	3	0.5
Malaria	2	0.4	0	0.0	4	0.7
Measles	0	0.0	0	0.0	0	0.0
Meningococcal Disease	9	1.7	4	0.7	7	1.2
Meningitis-Other Bacterial	8	1.5	5	0.9	7	1.2
Mumps	1	0.2	0	0.0	0	0.0
Pertussis	2	0.4	6	1.1	6	1.1
Plague	0	0.0	0	0.0	0	0.0
Poliomyelitis	0	0.0	0	0.0	0	0.0
Psittacosis	0	0.0	0	0.0	0	0.0
Rabies-Human	0	0.0	0	0.0	0	0.0
Rocky Mountain Spotted Fever	0	0.0	4	0.7	2	0.4
Rubella & Congenital Rubella Syndrome	0	0.0	0	0.0	0	0.0
Salmonellosis	58	10.9	56	9.8	72	12.6
Shigellosis	426	79.8	166	29.1	18	3.2
<i>Streptococcus pneumoniae</i> Invasive Disease						
Penicillin Resistant	22	4.1	52	9.1	42	7.4
Penicillin Sensitive	0	0.0	0	0.0	30	5.3
Tetanus	0	0.0	0	0.0	0	0.0
Toxic Shock Syndrome						
Staphylococcal	1	0.2	2	0.4	2	0.4
Streptococcal	1	0.2	0	0.0	1	0.2
Trichinosis	0	0.0	0	0.0	0	0.0
Tuberculosis-All Sites	74	13.9	60	10.5	81	14.2
Typhoid Fever	1	0.2	0	0.0	0	0.0
Vancomycin Resistant Enterococci	77	14.4	56	9.8	58	10.2
Varicella Deaths	0	0.0	0	0.0	0	0.0
Vibrio Infections	0	0.0	0	0.0	0	0.0
Yellow Fever	0	0.0	0	0.0	0	0.0
Yersiniosis	0	0.0	0	0.0	1	0.2
Total	1,297	242.9	1,476	259.0	1,274	223.6

[^]Denominator for calculating rate for 1998 was obtained from 1998 projected population data provided by Tennessee Department of Health. Denominator for calculating rates for 1999 and 2000 was U.S. Census 2000 data.

Table 36. Ten Most Frequently Reported Notifiable Diseases or Conditions 1998 - 2000, Nashville, Tennessee

	1998	1999	2000
1	Chlamydia (1,981)	Chlamydia (2,202)	Gonorrhea (2,404)
2	Gonorrhea (1,777)	Gonorrhea (1,785)	Chlamydia (2,403)
3	Influenza (450)	Influenza (867)	Influenza (720)
4	Shigellosis (426)	All Syphilis (506)	All Syphilis (522)
5	All Syphilis (416)	HIV (245)	AIDS (277)
6	HIV (203)	AIDS (191)	HIV (248)
7	AIDS (147)	Shigellosis (166)	Tuberculosis All Sites (81)
8	Vancomycin resistant enterococci (77)	Tuberculosis All Sites (60)	Salmonellosis (72)
9	Tuberculosis All Sites (74)	Salmonellosis (56)	Vancomycin resistant enterococci (58)
10	Salmonellosis (58)	Vancomycin resistant enterococci (56)	Hepatitis A (43)

Number of cases indicated in parenthesis.

Table 37. Ten Most Frequently Reported Notifiable Diseases or Conditions Excluding STDs/HIV/AIDS, 1998 - 2000, Nashville, Tennessee

	1998	1999	2000
1	Influenza (450)	Influenza (867)	Influenza (720)
2	Shigellosis (426)	Shigellosis (166)	Tuberculosis All Sites (81)
3	Vancomycin resistant enterococci (76)	Tuberculosis All Sites (60)	Salmonellosis (72)
4	Tuberculosis All Sites (74)	Salmonellosis (56)	Vancomycin resistant enterococci (58)
5	Salmonellosis (58)	Vancomycin resistant enterococci (56)	Acute hepatitis A (43)
6	Acute hepatitis B (45)	Penicillin resistant <i>streptococcus pneumoniae</i> Invasive Disease (52)	Penicillin resistant <i>streptococcus pneumoniae</i> Invasive Disease (42)
7	Acute hepatitis A (44)	Acute hepatitis A (50)	Campylobacteriosis (40)
8	Giardiasis (23)	Campylobacteriosis (34)	Acute hepatitis B (38)
9	Penicillin resistant <i>streptococcus pneumoniae</i> Invasive Disease (22)	Giardiasis (28)	Penicillin sensitive <i>streptococcus pneumoniae</i> Invasive Disease (30)
10	Campylobacteriosis (16)	Acute hepatitis B (22)	Giardiasis (23)
		Acute hepatitis C (22)	

Number of cases indicated in parenthesis.

3.4.1 Selected Notifiable Diseases/Conditions

The following sections will examine selected notifiable diseases by demographic characteristics and incidence. Where available, data will be presented comparing Nashville to other metropolitan areas of Tennessee, Tennessee, and the U.S. Information describing Nashville's progress towards achieving Healthy People 2010 objectives will be presented where appropriate.

Influenza (flu) is a continual public health challenge because the viruses that cause the disease are constantly changing. As a result, a new vaccine must be developed each flu season to combat the disease. With increased international travel, the fear always exists that a new type of flu virus could spread around the world quickly killing thousands of people, an influenza pandemic. This type of flu pandemic occurred in 1918 and 1919 killing more than 20 million people worldwide, approximately 500,000 in the U.S. alone. Other influenza pandemics occurred in 1957, Asian flu, and 1968, Hong Kong flu. Influenza is reported to the Metro Public Health Department by number of cases only, therefore, it is impossible to provide demographic information on those affected by this disease in Nashville.

Influenza (flu) is a continual public health challenge because the viruses that cause the disease are constantly changing.

3.4.1.1 Notifiable Diseases affecting the Gastrointestinal Tract

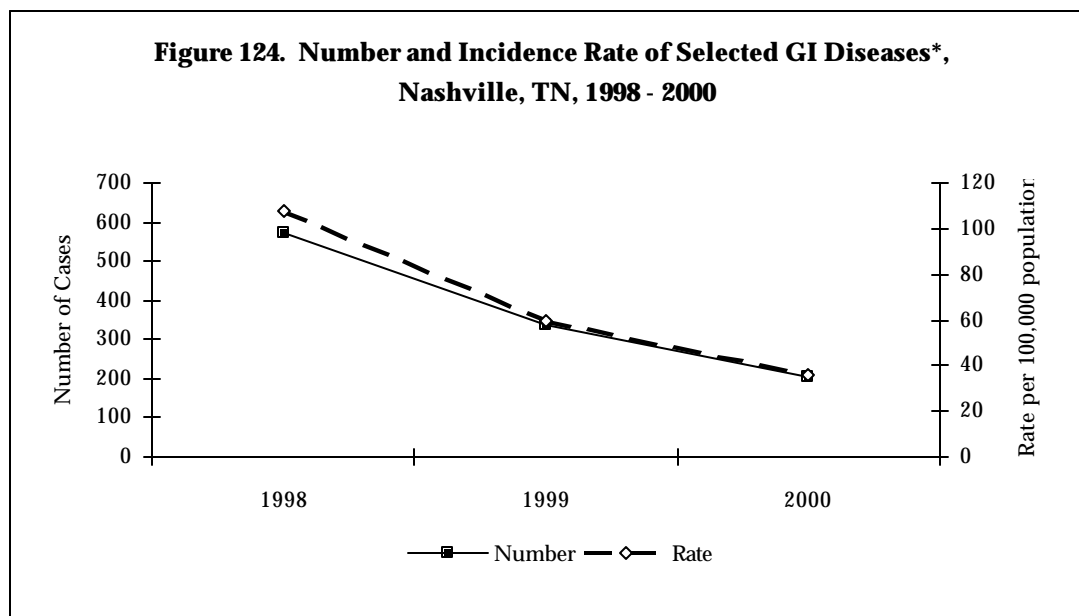
Background

Notifiable diseases that affect the gastrointestinal (GI) tract were consistently among the leading causes of morbidity between 1998 and 2000. The GI diseases most frequently reported to MPHD, transmitted through food, water, or other fecal-oral mechanism, include campylobacteriosis, *Escherichia coli* 0157:H7, giardiasis, salmonellosis, shigellosis, and hepatitis A. An outbreak of shigellosis occurred in Davidson and surrounding counties in 1998 and 1999. A concerted effort involving public health, medical providers, schools, and the media was required to control this outbreak that resulted in 426 confirmed cases in 1998 alone. Although the cost of this outbreak in the Nashville community is unknown, hospitalization costs for foodborne illnesses are estimated at over \$3 billion dollars a year in the U.S., and costs from lost productivity are much higher.¹ Seventy-four cases of giardiasis, an infection caused by a waterborne protozoan, were reported in Nashville during the three-year period. Increasingly in the U.S., the pathogens that cause waterborne diseases are resistant to routine disinfection methods. Of the waterborne outbreaks reported to the Centers for Disease Control and Prevention (CDC) during 1993 and 1994, more than half of those for which an infectious cause could be identified were due to chlorine-resistant microbes.¹

From 1998 to 2000 in Nashville, 54.7% of the reported diseases affecting the GI tract were shigellosis.

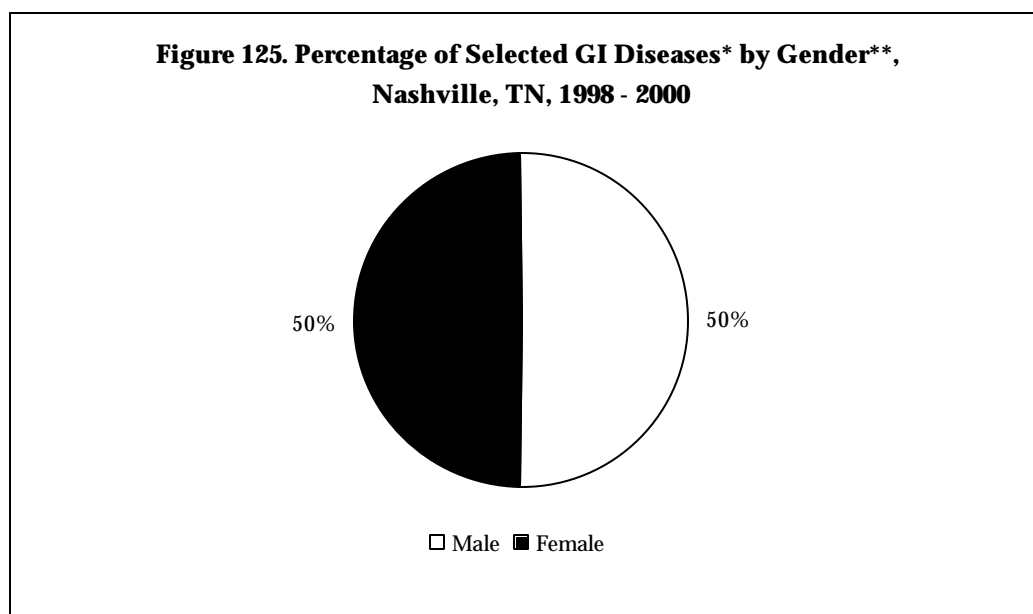
Findings

From 1998 to 2000 in Nashville, 54.7% of the reported diseases affecting the GI tract were shigellosis followed by salmonellosis, hepatitis A, campylobacteriosis, giardiasis, and *Escherichia coli* 0157:H7. As the shigellosis outbreak came under control in 1999, the incidence rate for the GI diseases declined from 107.5 per 100,000 population in 1998 to 35.8 in 2000 (Figure 124).



*Includes campylobacteriosis, *Escherichia coli* 0157:H7, giardiasis, salmonellosis, shigellosis, and hepatitis A

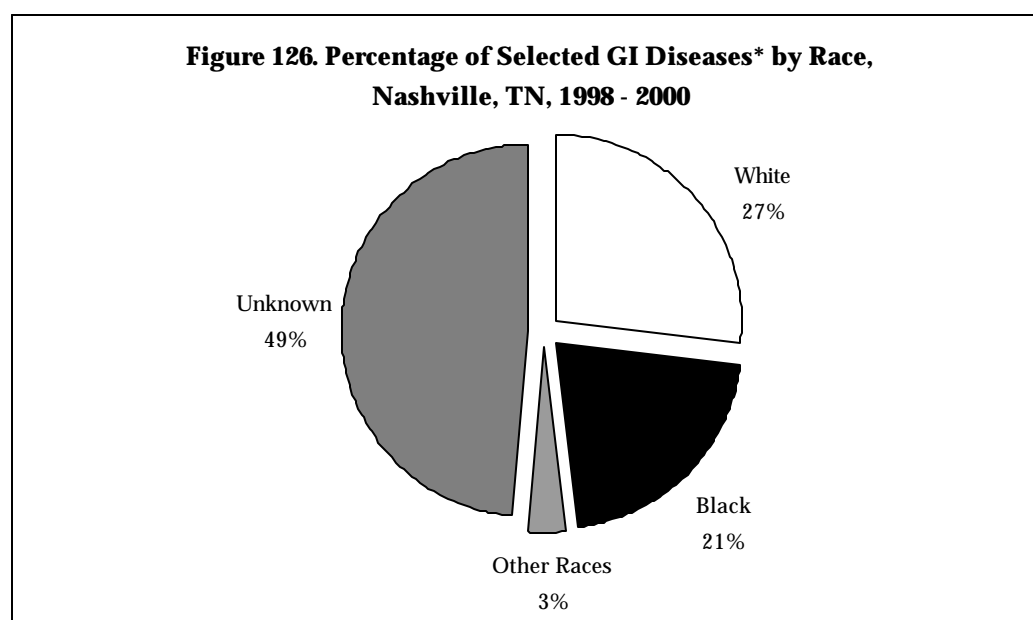
Reported GI diseases were present equally in the male and female populations (Figure 125).



*Includes campylobacteriosis, *Escherichia coli* 0157:H7, giardiasis, salmonellosis, shigellosis, and hepatitis A

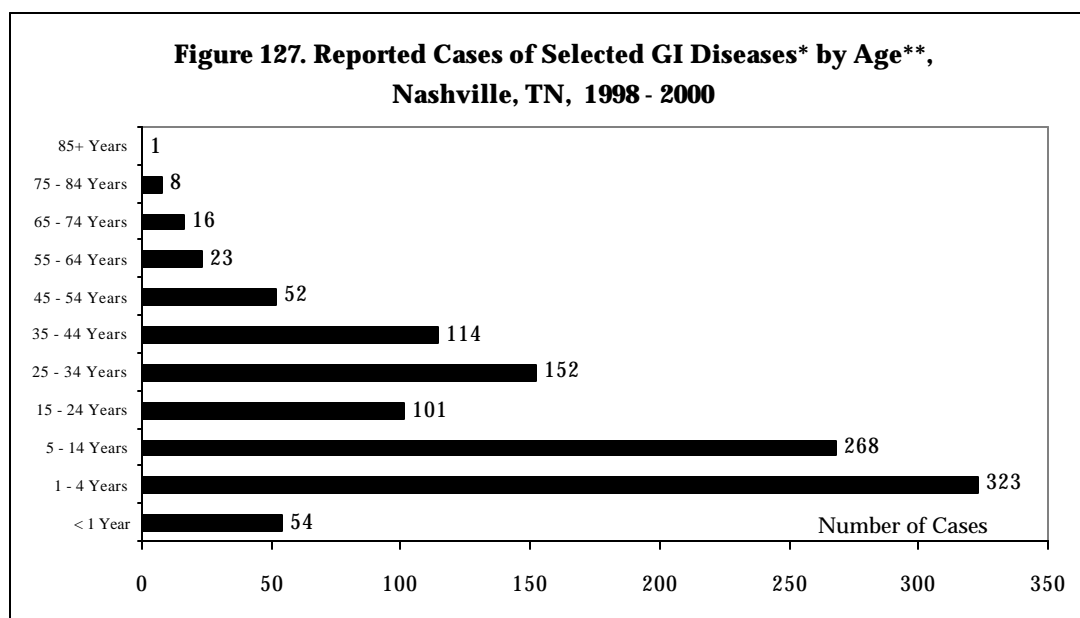
**Gender unknown for 5 cases

As seen in Figure 126, race information was not available for 49% of the cases of GI diseases, 27% of cases were white, 21% were black, and 3% were of other races.



*Includes campylobacteriosis, *Escherichia coli* 0157:H7, giardiasis, salmonellosis, shigellosis, and hepatitis A

The reported GI cases occurred predominantly among the youngest residents of Nashville (Figure 127). Thirty-three percent of cases were among children 4 years of age and younger; 57.8% of cases were under the age of 25.



*Includes campylobacteriosis, *Escherichia coli* 0157:H7, giardiasis, salmonellosis, shigellosis, and hepatitis A

**Age unknown for 4 cases

When compared to the three other large metropolitan areas of the state, in the year 2000 Nashville ranked third to Knoxville and Memphis in number of reported cases of the selected gastrointestinal diseases (Table 38). Nashville's rate of 35.8 per 100,000 was higher than the rate for Tennessee (30.4). Only provisional 2000 data is available for the U.S. and only for selected diseases. Nashville's rate of disease was less than the U.S. rate for *Escherichia coli* 0157:H7, salmonellosis, and shigellosis. However, the incidence rate of hepatitis A in Nashville, 7.5, exceeded the rate for the U.S., 4.4.

Healthy People 2010 Objective 14-6 calls for the reduction of hepatitis A cases to 4.5 cases per 100,000 population. From 1998 - 2000, Nashville's incidence rate remained above the objective (Figure 128).

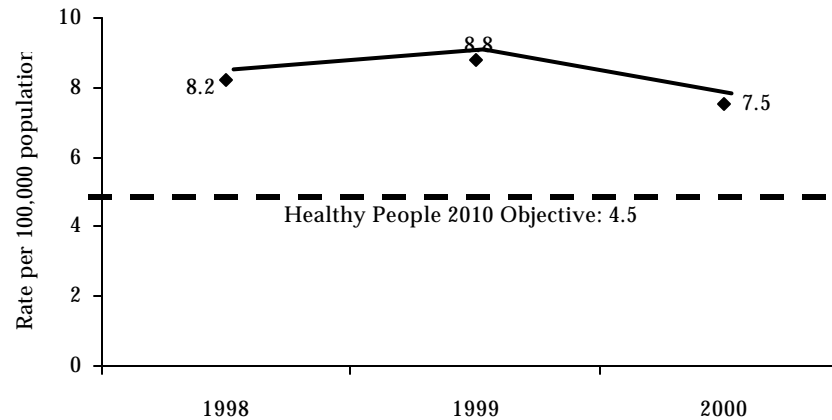
Other diseases on the list of notifiable diseases/conditions may affect the gastrointestinal tract or be spread through the food or water. This list includes botulism, cholera, listeriosis, brucellosis, cyclospora, cryptosporidiosis, trichinosis, and yersiniosis. Fifteen cases of these diseases were reported in Nashville from 1998 - 2000. Eight cases of listeriosis were reported in this period. Listeriosis is a bacterial disease whose transmission has been associated with contaminated milk, cheese, and vegetables. Five cases of cryptosporidiosis were reported in Nashville during the three-year period. *Cryptosporidium* caused the largest single waterborne disease outbreak in the U.S. in 1993, affecting more than 400,000 people.

Table 38. Comparison of Selected Gastrointestinal Diseases, Nashville, Memphis, Knoxville, Chattanooga, Tennessee, and U.S.*, 2000

Area	All Selected Gastrointestinal Diseases		Campylobacteriosis		Escherichia coli 0157:H7		Giardiasis		Hepatitis A		Salmonellosis		Shigellosis	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Nashville	204	35.8	40	7.0	8	1.4	23	4.0	43	7.5	72	12.6	18	3.2
Memphis	264	29.4	27	3.0	1	0.1	27	3.0	34	3.8	115	12.8	60	6.7
Knoxville	285	74.6	41	10.7	6	1.6	19	5.0	9	2.4	53	13.9	157	41.1
Chattanooga	46	14.9	8	2.6	2	0.6	8	2.6	3	1.0	22	7.1	3	1.0
Tennessee	1,728	30.4	280	4.9	61	1.1	183	3.2	153	2.7	697	12.3	354	6.2
U.S.	NA**		NA		4,410	1.6	NA		12,275	4.4	36,762	13.1	20,721	7.4

*U.S. data provisional taken from MMWR, January 5, 2001/Vol.49/Nos.51&52. Rate calculated using 2000 census population.

** Not available

Figure 128. Incidence Rate of Hepatitis A Compared to Healthy People 2010 Objective, Nashville, TN, 1998 - 2000

Discussion

Understanding the method of spread of these diseases and the fact that predominantly children were affected by the diseases in the period 1998 - 2000, it is easy to understand why information pertaining to the importance of and proper techniques for good hand-washing provided in schools and through the media were effective in helping to control the shigellosis outbreak in 1998 and 1999. Ongoing education pertaining to hand-washing is provided by the Division of Notifiable Disease Control/Immunization Promotion within the community and the school system. In addition, the Division of Food Protection inspects all establishments within the county that serve food to the public at least twice per year. Staff of the Division of Food Protection also participate in a variety of food protection training programs, some provided in Chinese and Spanish as well as English, designed to educate the community at large as well as managers and employees of food establishments. For more information about MPHD's Food Protection Division refer to Section 2.1.2.6.

Reference:

1. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Preventing emerging infectious diseases. a strategy for the 21st century [online]. 1998. Available at: <http://www.cdc.gov/ncidod/emergplan/planrequest.htm>. Accessed February 13, 2002.

Information pertaining to the importance of and proper techniques for good hand-washing provided in schools and through the media were effective in helping to control the shigellosis outbreak in 1998 and 1999.

3.4.1.2 Tuberculosis

Background

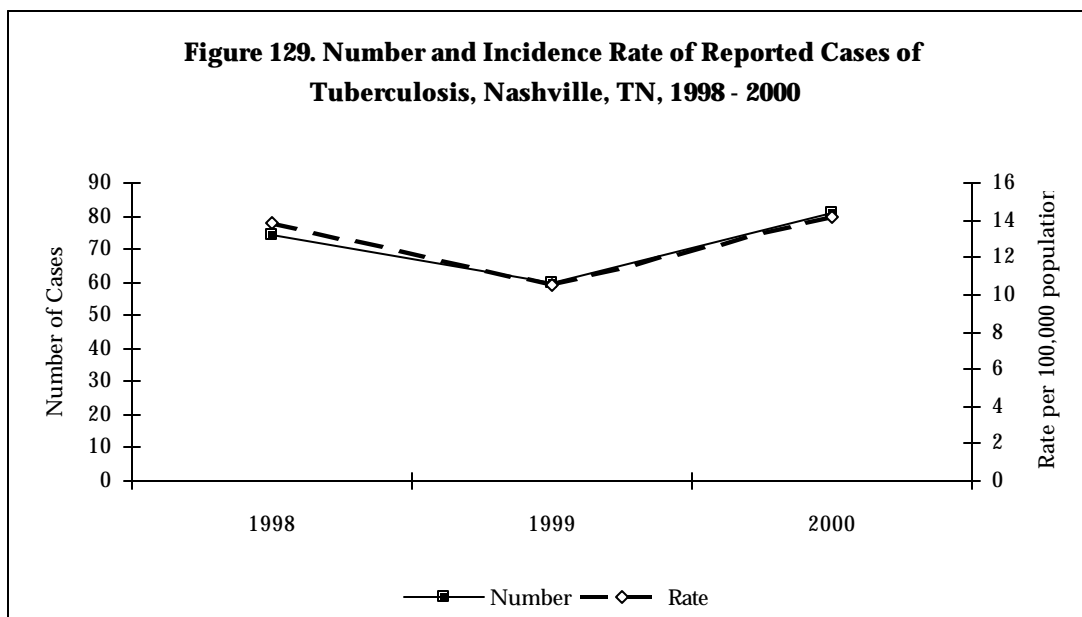
Nationwide reporting of tuberculosis (TB) began in 1953. That year there were 84,000 cases reported. Reported cases declined every year through 1984 by an average of 6%. However, between 1985 and 1992, the trend reversed and reported cases increased by 20% in the U.S. This increase was attributed to four factors: 1) the HIV epidemic, 2) immigration from countries where TB is common, 3) spread of TB in specific environments such as correctional facilities and homeless shelters, and 4) inadequate funding for TB control and other public health efforts.¹ From 1992 – 2000, additional resources were directed towards combating the resurgence of TB with a resulting decline in cases. In 2000, there were 16,377 cases of TB reported in the U.S., the fewest cases reported since 1953.²

Although diagnosis and treatment of tuberculosis have always been a challenge, these challenges are greater today. TB patients who do not complete the entire course of their medication therapy can develop, and spread, a strain of TB that is resistant to many of the drugs available to treat the disease. One case of multi-drug resistant TB can cost \$1 million to treat. An increasing number of the reported cases of TB are among foreign-born persons, 46% of cases in 2000 in the U.S. Persons exposed to TB disease may develop latent TB infection (LTBI). There are an estimated 10 to 15 million people in the U.S. with LTBI. About 10% of these people will develop TB disease at some time in their lives. People co-infected with HIV and TB are up to 800 times more likely to develop active TB disease during their lifetime than people without HIV infection.²

Although diagnosis and treatment of tuberculosis have always been a challenge, these challenges are greater today.

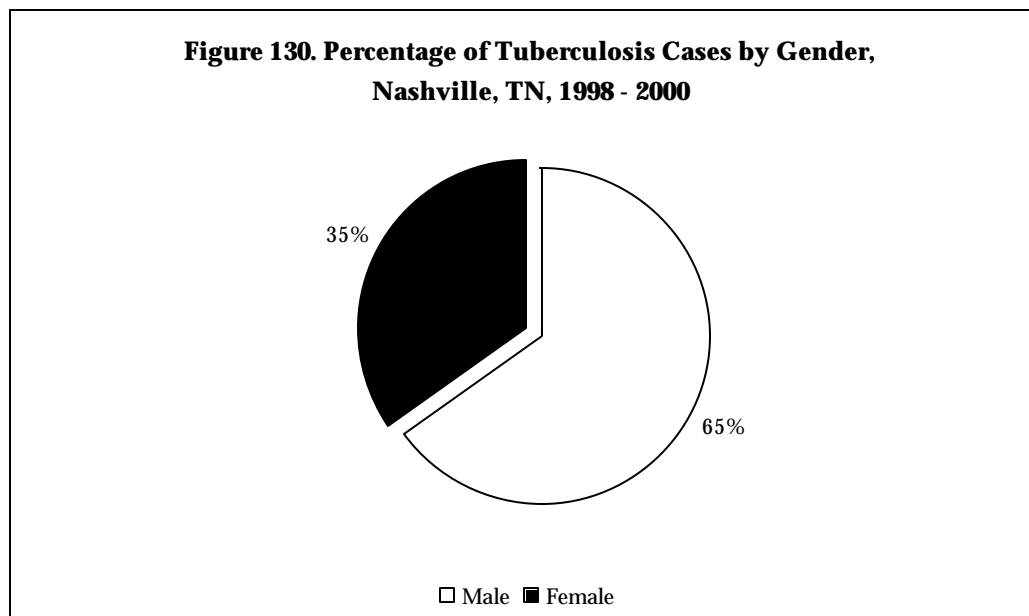
Findings

Nashville did not follow the national trend of fewest reported cases of TB in 2000. Figure 129 presents number of cases and incidence rate of TB in Nashville from 1998 to 2000. Although the number of cases declined in 1999, there was a 25.9% increase in reported cases from 1999 (60 cases) to 2000 (81 cases).



Eighty-four percent of the reported TB cases (180 cases) from 1998 to 2000 were pulmonary TB. The major site of TB infection in the other cases (35 cases) included pleural, lymphatic/cervical, lymphatic/intrathoracic, lymphatic other, bone and/or joint, genitourinary, miliary, meningeal, peritoneal, and other.

Sixty-five percent of reported tuberculosis cases were among males and 35% of cases were among females from 1998 to 2000 in Nashville (Figure 130).



Twice as many cases of tuberculosis were of the black race as compared to whites between 1998 and 2000 (131 cases/66 cases). Six percent of cases were among persons of other races (Figure 131). When examining tuberculosis cases by ethnicity over the three year period, the great majority of cases, 96%, were non-Hispanic.

One quarter of new cases of TB occurred in persons between the ages of 35 and 44 in years 1998 to 2000 (53 cases/24.6%). Over half of the reported cases during the 3 - year period were in persons between the ages of 25 and 54 (126 cases/58.6%) (Figure 132).

Nashville's percentage of foreign-born cases in 2000 was well below the national level of 46%. In 1999, 26.7% of reported cases of tuberculosis were among foreign-born persons, decreasing only slightly in 2000 to 25.9% of cases. During the three-year period, 52 of the 215 cases were foreign-born. These foreign-born cases were from twenty different countries. Over half (51.9%) came from four countries: Somalia, Ethiopia, India, and Sudan (Figure 133).

A total of 60 tuberculosis cases were also homeless during the years 1998 to 2000. The fewest homeless cases occurred in 2000 with a total of 18 cases (22.2% of cases) down from 22 cases (36.7%) in 1999. Nationwide in 2000, 6.1% of tuberculosis cases were homeless (Figure 134).

Approximately 10% - 15% of the national total of TB cases are reported among persons living with HIV. ² In Nashville from 1998 to 2000, 15.3% of the tuberculosis cases were living with HIV (Figure 135).

Figure 131. Percentage of Tuberculosis Cases by Race*, Nashville, TN, 1998 - 2000

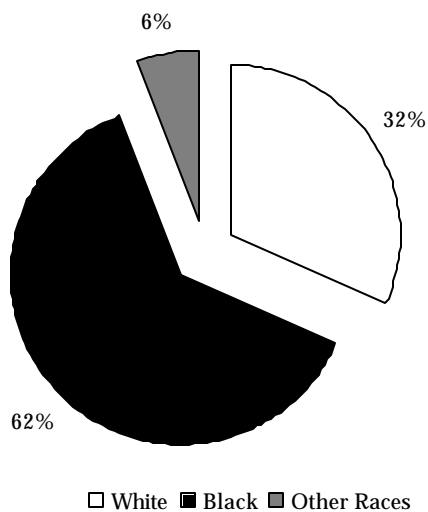
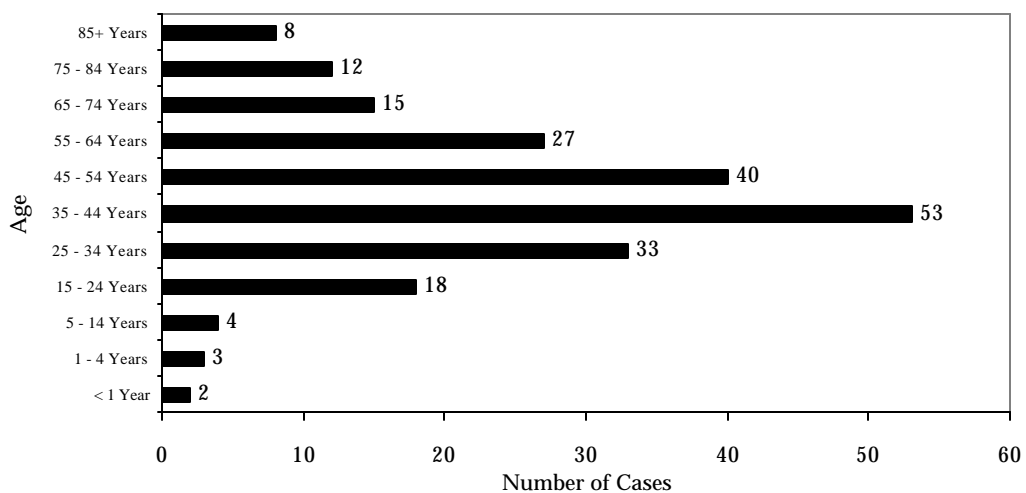


Figure 132. Reported Cases of Tuberculosis by Age, Nashville, TN, 1998 - 2000



Although the number of cases declined in 1999, there was a 25.9% increase in reported cases from 1999 (60 cases) to 2000 (81 cases).

Figure 133. Number and Percent of Foreign-born Tuberculosis Cases, Nashville, TN, 1998 - 2000

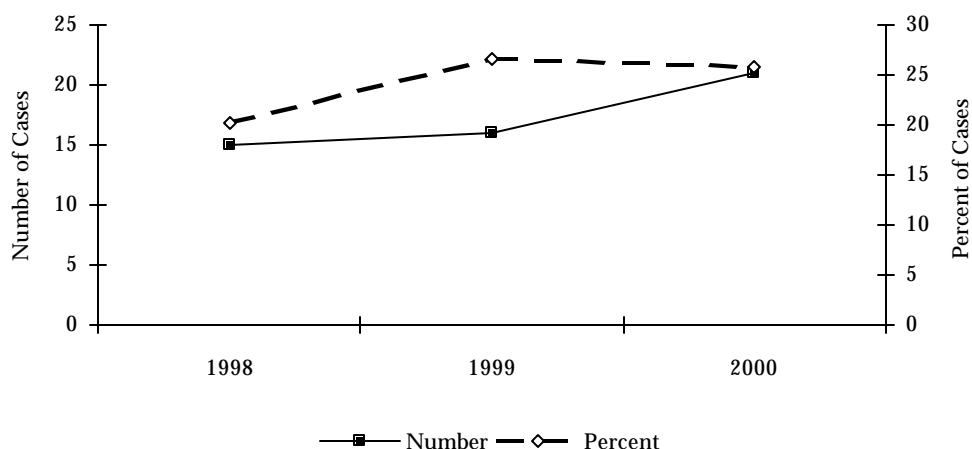
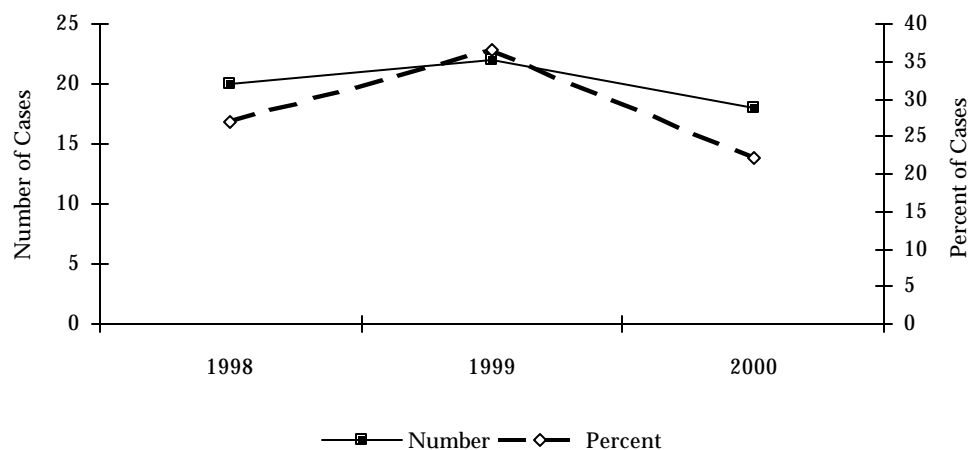


Figure 134. Number and Percent of Tuberculosis Cases Who Were also Homeless, Nashville, TN, 1998 - 2000



Eighty-four percent of the reported TB cases (180 cases) from 1998 to 2000 were pulmonary TB.

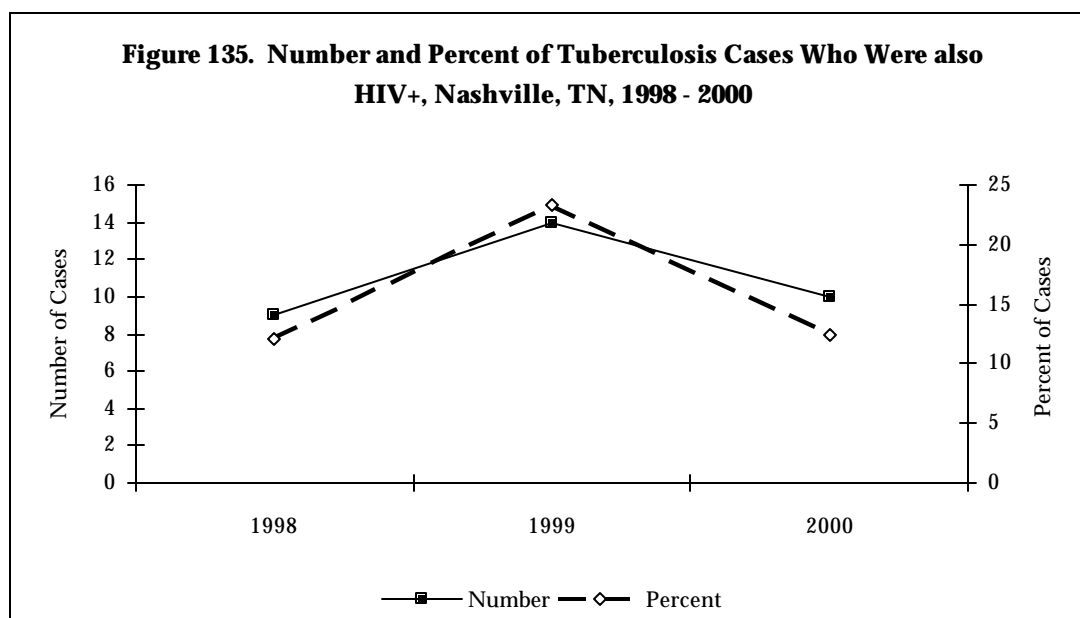


Table 39. Comparison of Number and Incidence Rates of New Tuberculosis Cases , Nashville, Memphis, Knoxville, Chattanooga, Tennessee, and U.S.* , 2000

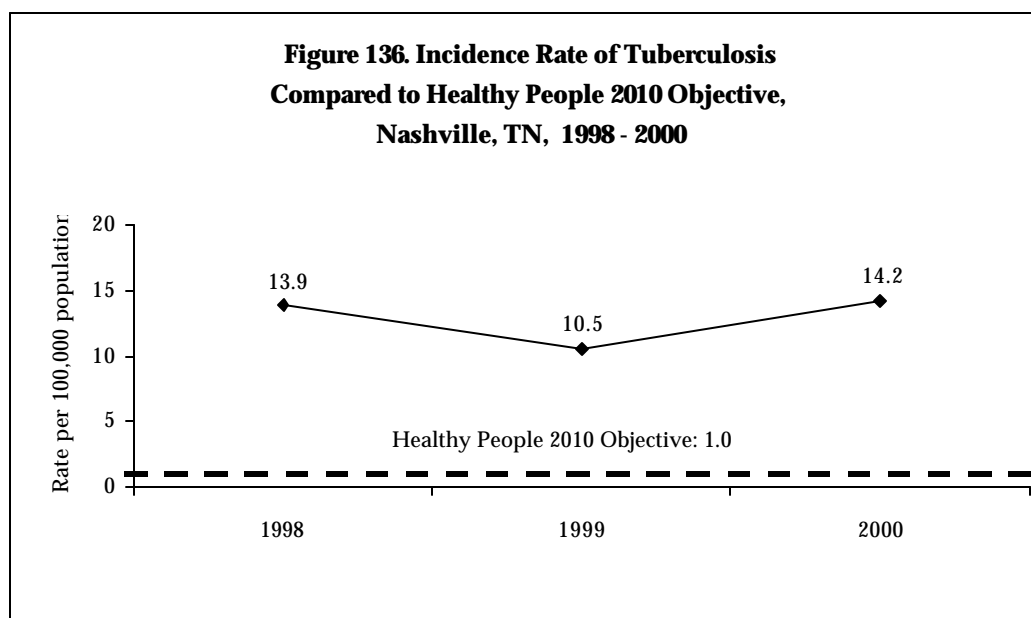
Area	Tuberculosis	
	Number	Rate
Nashville	81	14.2
Memphis	80	8.9
Knoxville	19	5.0
Chattanooga	24	7.8
Tennessee	383	6.7
U.S.	12,942	4.6

*U.S. number is provisional taken from MMWR, January 5, 2001/Vol.49/Nos.51&52. Rate calculated using 2000 U.S. census population.

Nashville's rate was more than double the rate for Tennessee (14.2 / 6.7) and more than three times the provisional 2000 rate for the U.S.

In 2000, Nashville led the three other metropolitan areas and Tennessee in the incidence rate for tuberculosis. Nashville's rate was more than double the rate for Tennessee (14.2 / 6.7) and more than three times the provisional 2000 rate for the U.S. (Table 39).

Healthy People 2010 Objective 14-11 calls for the reduction of the incidence rate for tuberculosis from the 1998 baseline of 6.8 to 1.0. Nashville's incidence rate per 100,000 in 1999, the lowest of the three years 1998 to 2000, was greater than 10 times the 2010 Objective (Figure 136).



Discussion

Nationally, several factors are thought to have contributed to the decline in reported tuberculosis cases since 1992. Activities were aimed at quickly identifying people with TB, beginning them on the appropriate medications as soon as possible, and making sure that they completed the entire course of medications in a timely manner. The incidence of AIDS declined. The number of cases of TB that were resistant to multiple drugs decreased. Infection control practices in health care settings and areas where large numbers of persons reside, i.e., prisons or nursing homes, improved.³

The Advisory Council for the Elimination of Tuberculosis and a report from the Institute of Medicine, *Ending Neglect: The Elimination of Tuberculosis in the United States*, have both emphasized that the current efforts directed at tuberculosis management need to be maintained and enhanced if the United States is to move from TB control to TB elimination. Locally, MPHD provides multiple services aimed at preventing the spread of active TB disease and preventing persons with LTBI from developing disease. Directly observed therapy (DOT), as recommended by the CDC, is the standard of care for all persons in Nashville who are suspected of having or who do have active tuberculosis. MPHD TB staff observe each of these patients taking their medications throughout the duration of treatment. This is one way of ensuring that people do not forget doses of medication which may lead to drug resistant TB and the continued spread of active TB disease. Social services assist those persons with TB with basic necessities if they are restricted from work and social activities. Outreach activities focus on specific educational presentations identifying the difference between active disease and latent TB infection. These activities recognize the various cultural beliefs of different groups of people and need for information in multiple languages. For additional information about the work of the Division of Tuberculosis Elimination, please call 615-340-5650.

References:

1. Centers for Disease Control and Prevention. Self study modules on tuberculosis. module2: epidemiology of tuberculosis. 1999 [online]. Available at: <http://www.phppo.cdc.gov/PHTN/tbmodules/modules1-5/m2/2-m-02.htm>. Accessed March 11, 2002.
2. Centers for Disease Control and Prevention. TB elimination: now is the time. 2002 [online]. Available at: <http://www.cdc.gov/nchstp/tb>. Accessed March 8, 2002.
3. National Center for HIV, STD and TB Prevention. Division of TB Elimination. *Reported TB in the U.S. 2000*. Centers for Disease Control and Prevention: October 2, 2001.

Directly observed therapy (DOT), as recommended by the CDC, is the standard of care for all persons in Nashville who are suspected of having or who do have active tuberculosis.

3.4.1.3 Notifiable Conditions Related to Antimicrobial Resistance

Background

Antimicrobial drugs altered the treatment and method of health care for many diseases that once caused serious illness and death. However, widespread use and misuse of these drugs have reduced their effectiveness over the years as many microbes have developed resistance to the drugs. Antimicrobial resistance occurs when microbes adapt to survive the use of medications meant to kill or weaken them, making the infection more difficult or impossible to treat. A person infected with a resistant organism can pass that resistant organism to another person, allowing the resistant organism to spread from person-to-person.¹

One hundred sixteen cases of penicillin resistant *Streptococcus pneumoniae* invasive disease were reported in Nashville from 1998 to 2000.

Bacteria, fungi, and viruses can become resistant to drugs.² Antimicrobial resistant strains have developed in many microbes once considered easily treatable, such as those that cause tuberculosis, malaria, ear infections, pneumonia, and some foodborne infections. People infected with drug-resistant organisms require hospitalization more frequently, are in the hospital for longer periods of time, and are more likely to die as a result of the infection. There are increasingly limited options to treat resistant infections, and the drugs may be less effective, more toxic, more expensive, and more difficult to administer. A 1995 U.S. government report estimated that antimicrobial resistance among six common bacteria in hospitals adds approximately \$661 million per year in hospital charges. This is an underestimate because it does not include indirect costs, such as costs of lost days of work.¹

In Tennessee, penicillin resistant *Streptococcus pneumoniae* (DRSP) and Vancomycin resistant enterococci (VRE) are on the list of notifiable diseases and conditions.

Findings

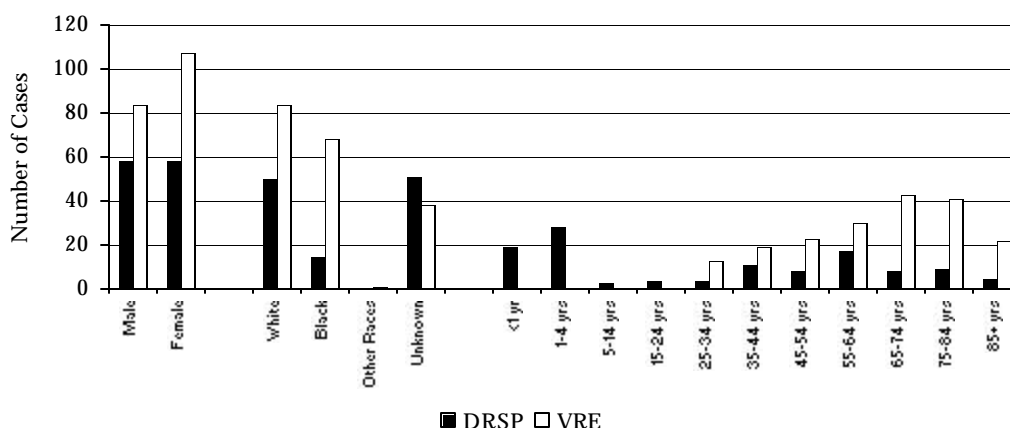
Figure 137 may be used to compare DRSP and VRE. One hundred sixteen cases of penicillin resistant *Streptococcus pneumoniae* invasive disease were reported in Nashville from 1998 to 2000. These cases were evenly divided among males and females. Race information was unavailable for 44% of cases; 43% were white; 13% were black, and no cases were reported among persons of other races. Forty-one percent (47 cases) of the cases were in children under the age of 5 years, and one half of the cases were 35 years of age and older.

In 2000, the incidence rate per 100,000 population for DRSP was 7.4, down from 9.1 in 1999. Nashville ranked third of the four largest metropolitan areas of Tennessee in reported cases and incidence rate of penicillin resistant *Streptococcus pneumoniae* in 2000. However, Nashville's incidence rate of 7.4 was greater than the rate for Tennessee (4.7) (Table 40).

Of the 191 cases of VRE reported in Nashville between 1998 and 2000, 56% were female. Forty-three percent of the cases were white, followed by 36% black, and 1% other races. Race information was not available for 20% of the cases. Greater than one half of the cases were over the age of 64 (106 cases/55.5%).

The 2000 incidence rate of 10.2 per 100,000 population for VRE was up from 9.8 in 1999. Comparing VRE among the metropolitan areas of Tennessee, Nashville ranked second to Memphis both in number of reported cases and incidence rate in 2000 (Table 40).

Figure 137. Comparison of DRSP and VRE by Gender, Race, and Age, Nashville, TN, 1998 - 2000



Of the 191 cases of VRE reported in Nashville between 1998 and 2000, 56% were female.

Table 40. Comparison of Number and Incidence Rates of DRSP and VRE, Nashville, Memphis, Knoxville, Chattanooga, and Tennessee, 2000

Area	DRSP		VRE	
	Number	Rate	Number	Rate
Nashville	42	7.4	58	10.2
Memphis	51	5.7	239	26.6
Knoxville	49	12.8	12	3.1
Chattanooga	26	8.4	12	3.9
Tennessee	266	4.7	524	9.2

*U.S. data not available

Discussion

Each year in the U.S. *Streptococcus pneumoniae* infections cause 100,000 to 135,000 hospitalizations for pneumonia, 6 million ear infections, and 3,300 cases of meningitis. Forty percent of these infections are drug resistant.³

Enterococci are bacteria that are found in the intestine of nearly all animals. Each year enterococci cause approximately 110,000 urinary tract infections, 25,000 cases of bacteremia, 40,000 wound infections, and 1,100 cases of endocarditis in the U.S. Most of these infections occur in hospitalized patients.⁴ Enterococci are increasingly found to be resistant to Vancomycin, the antibiotic used when all other licensed drugs are ineffective. Vancomycin-resistant enterococci were first reported in Europe in 1988. From 1989, the year VRE was identified in the U.S., through 1993 the percentage of hospital-acquired infections caused by VRE increased by 20-fold (from 0.3% to 7.9%).⁵

In order to address this growing problem, the Tennessee Department of Health (TDH) has begun a statewide Appropriate Antibiotic Use Campaign. The campaign will focus on educating parents and health care providers about the importance of appropriate antibiotic use and risks of resistance. In the spring of 2002, clinicians, parents, pharmaceutical companies, day care center staff, and other interested parties formed a coalition to get the message out about proper antibiotic use. MPH is a member of the coalition and will work to address the appropriate use of antibiotics in Nashville.

References:

1. U.S. Department of Health and Human Services. Antimicrobial resistance: the public health response fact sheet. 2001 [online]. Available at: <http://www.hhs.gov/news/press/2001pres/01fsdruresistance.html>. Accessed March 3, 2002.
2. National Center for Infectious Diseases. Centers for Disease Control and Prevention. Antimicrobial resistance: a growing threat to public health. 2001 [online]. Available at: http://www.cdc.gov/ncidod/hip/ARESIST/am_res.htm. Accessed March 3, 2002.
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5. McDonald L, Kuehnert M, Tenover F, Jarvis W. Vancomycin-resistant enterococci outside the health-care setting: prevalence, sources, and public health implications. *Emerging Infectious Diseases* 1997; Vol3 No3 [online]. Available at: <http://www.cdc.gov/ncidod/eid/vol3no3/mcdonald.htm>. Accessed March 3, 2002.

From 1989, the year VRE was identified in the U.S., through 1993 the percentage of hospital-acquired infections caused by VRE increased by 20-fold (from 0.3% to 7.9%).

3.4.1.4 Hepatitis B and C

Background

Only acute cases of hepatitis B and C and hepatitis B occurring among pregnant women are on the list of notifiable diseases/conditions in Tennessee. After acute infection with hepatitis B virus (HBV), the risk of developing chronic infection is associated inversely with age; chronic HBV infection occurs among about 90% of infants infected at birth, 20% - 50% of children infected at 1 to 5 years of age, and about 1% to 10% of persons infected as older children and adults. An estimated 15% to 25% of persons with chronic HBV infection will die prematurely of either cirrhosis or liver cancer. HBV may be the cause of up to 80% of cases of liver cancer worldwide, second only to tobacco among known human carcinogens.¹

Hepatitis C virus (HCV) infection is the most common chronic blood-borne infection in the U.S.

Hepatitis C virus (HCV) infection is the most common chronic blood-borne infection in the U.S. The CDC estimates that during the 1980s, an average of 242,000 new infections occurred each year. Since 1989, the annual number of new infections has declined by > 80% to 36,000 by 1996. It is estimated that 3.9 million (1.8%) Americans have been infected with HCV. Most of these persons are chronically infected and may not be aware of the infection because they do not exhibit symptoms. However, they may serve as a source of transmission to others and are at risk for chronic liver disease during the first two or more decades following initial infection. Population based studies indicate that 40% of chronic liver disease is HCV-related with a resulting 8,000 to 10,000 deaths per year. Current estimates of medical and work-loss costs of HCV-related acute and chronic liver disease are > \$600 million annually. HCV-associated end-stage liver disease is the most frequent indication for liver transplantation among adults.²

Findings

More than twice as many cases of acute hepatitis B (105 cases) than acute hepatitis C (44 cases) were reported in Nashville during the 1998 to 2000 period. The incidence rate for acute hepatitis B rose from 1999 to 2000 while the incidence rate for acute hepatitis C declined slightly during the same period. The number of reported cases of hepatitis B in pregnant women increased from 2 cases in 1998 to 22 cases in 2000, a 1,000% increase (Figures 138 - 140).

Both acute hepatitis B and C were reported more frequently among males than females. Overall, 52% of reported cases of these diseases were male. Figure 141 may be used to compare gender, race, and age for acute hepatitis B and C.

Race information was unavailable for 38% of acute hepatitis B and C cases; 36% were white; 22% were black; and 4% were of other races. However, the race distribution differs when looking at hepatitis B infection among pregnant women during the three-year period. While race information was unavailable for 44% of the cases, hepatitis B infection in pregnant women was found more frequently among women of other races (33%) followed by black (19%) and white (4%)(Figure 142).

Both acute hepatitis B and C affected persons between the ages of 35 and 44 years most frequently with 40% of the cases falling within this age group. Sixty percent of pregnant women with hepatitis B infection were between the ages of 25 and 34.

Figure 138. Number and Incidence Rate of Acute Hepatitis B, Nashville, TN, 1998 - 2000

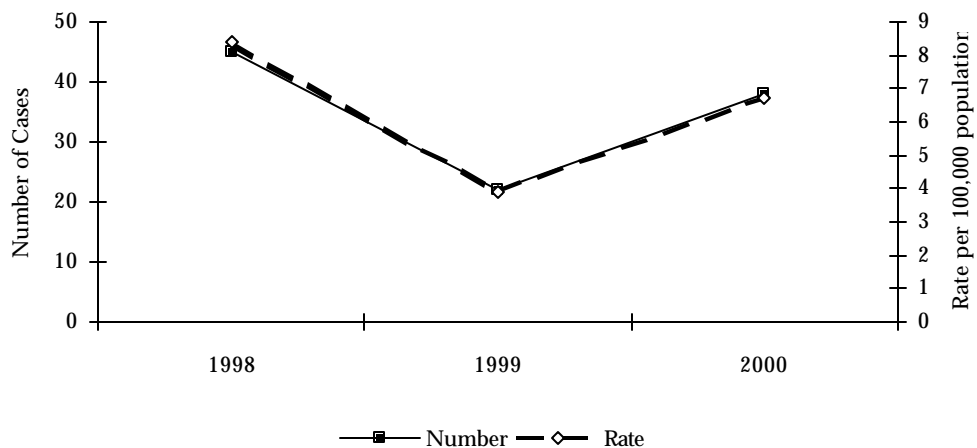
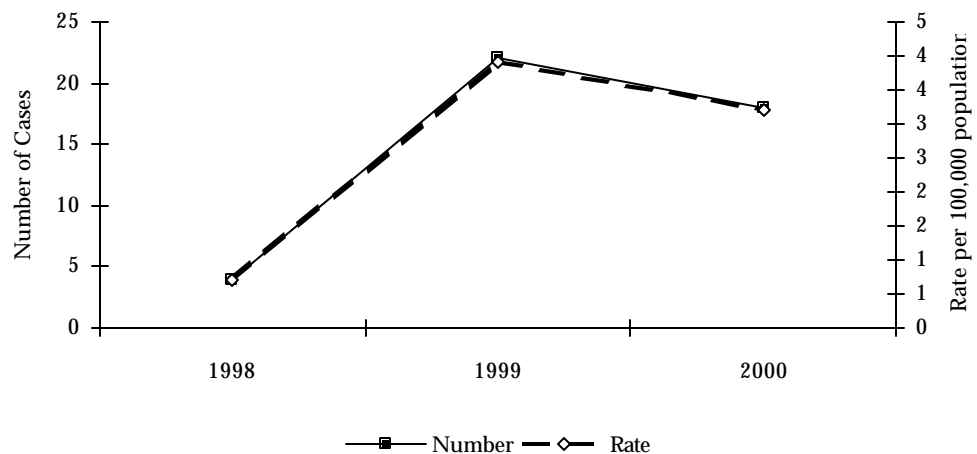
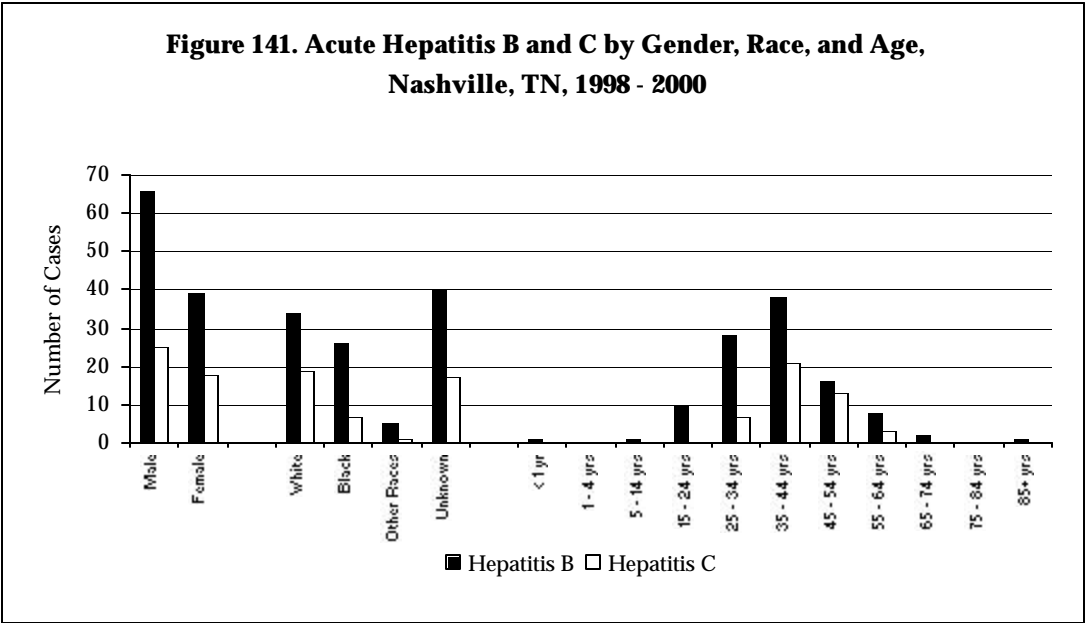
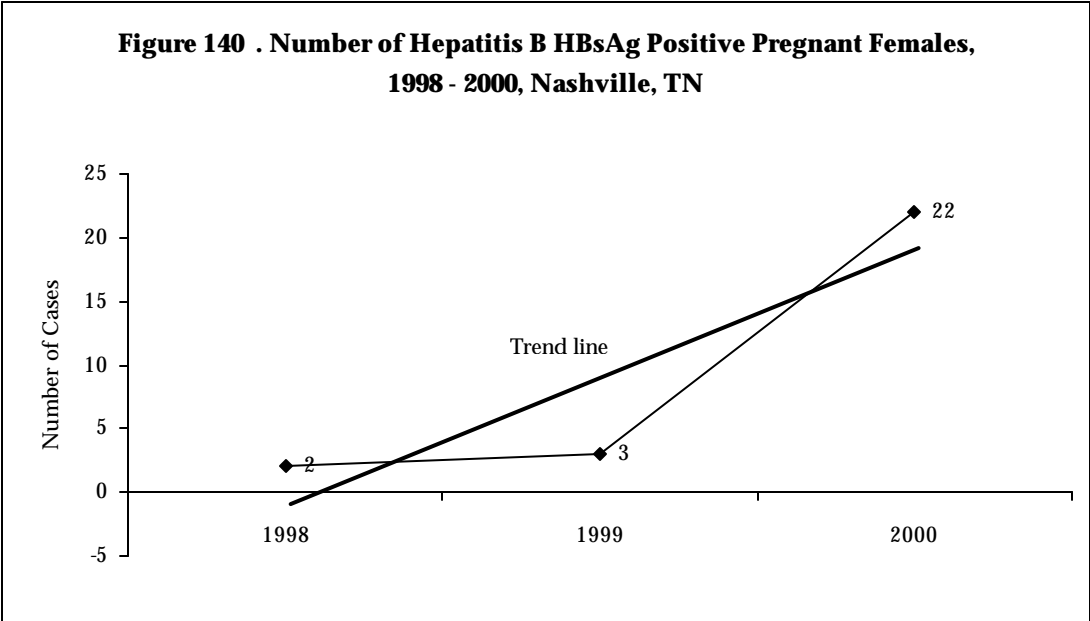


Figure 139. Number and Incidence Rate of Acute Hepatitis C, Nashville, TN, 1998 - 2000

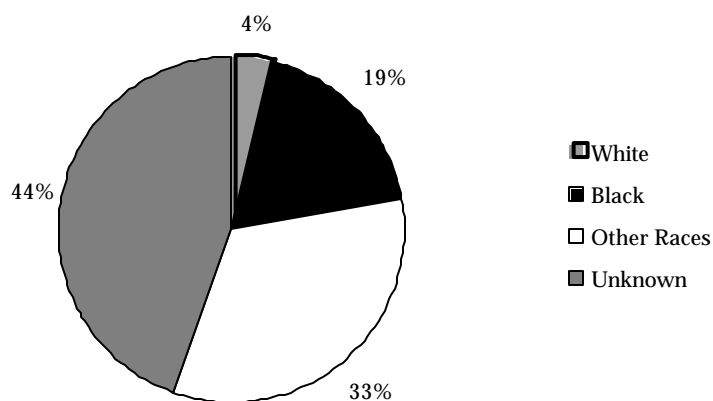


More than twice as many cases of acute hepatitis B (105 cases) than acute hepatitis C (44 cases) were reported in Nashville during the 1998 to 2000 period.



Nashville's incidence rates for both acute hepatitis B and C were above that of the Tennessee rate for the year 2000.

Figure 142. Percentage of Hepatitis B, HBsAg Positive Pregnant Females by Race, Nashville, TN, 1998 - 2000



Nashville's incidence rates for both acute hepatitis B and C were above that of the Tennessee rate for the year 2000 (Table 41). Nashville ranked second to Memphis for incidence per 100,000 population for acute hepatitis B and second to Chattanooga for incidence per 100,000 for acute hepatitis C in the same year. Examining the provisional U.S. 2000 data, Nashville's rate for hepatitis B was more than double the U.S. rate, and the hepatitis C rate was three times greater than that of the U.S.

Table 41. Comparison of Number and Incidence Rates of Acute Hepatitis B and C, Nashville, Memphis, Knoxville, Chattanooga, Tennessee, and U.S.*, 2000

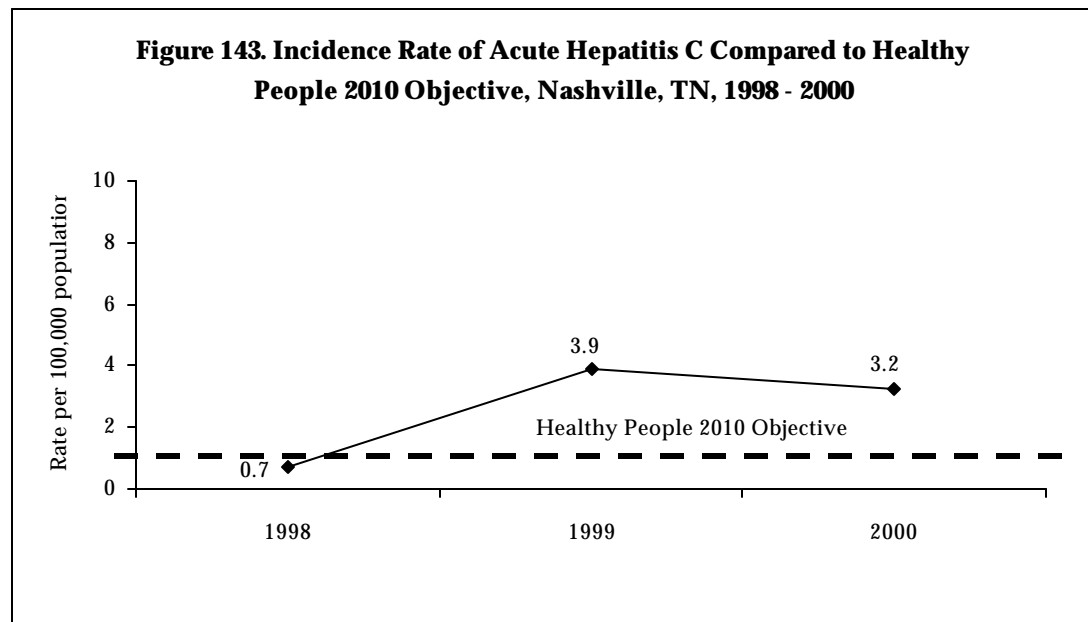
Area	Acute Hepatitis B		Acute Hepatitis C	
	Number	Rate	Number	Rate
Nashville	38	6.7	18	3.2
Memphis	85	9.5	1	0.1
Knoxville	14	3.7	1	0.3
Chattanooga	16	5.2	28	9.1
Tennessee	220	3.9	105	1.8
U.S.	6,646	2.4	2,895	1.0

*U.S. data provisional taken from MMWR, January 5, 2001/Vol.49/Nos.51&52. Rate calculated using 2000 census population.

Healthy People 2010 Objective 14-1 addresses hepatitis B in persons 2 to 18 years of age. Cases in Nashville within this age range decreased from two cases in 1998 to 0 cases in 2000. Objective 14-3 pertains to hepatitis B as it affects specific age groups and persons with specific risk factors. With the exception of the adult 40+ age group in 1999, Nashville's numbers have exceeded the objective consistently during the three-year period. For the 25 to 39 year age group, Nashville's rate per 100,000 population was more than double the objective rate in 1998 and 2000. Transmission of HBV can occur

by sharing of needles by injecting drug users. Anal intercourse is also associated with an increased risk of infection. Nosocomial transmission may occur by several methods including transfusion and hemodialysis, but also through needlesticks and other sharp instrument injuries to medical personnel.¹

HCV was discovered by molecular cloning in 1988. The disease is transmitted primarily by blood transfusion or injecting drug use. HCV infections acquired 15 or more years ago were acquired primarily as a result of a blood transfusion. However, CDC data shows that transfusion rarely accounts for recently acquired infections. In contrast, injecting drug use currently accounts for 60% of HCV transmission in the U.S.² In 1999 and 2000, Nashville's incidence rate for hepatitis C was more than 3 times the Healthy People 2010 Objective 14-9 (Figure 143).



Discussion

Although chronic hepatitis B and C infections are not reportable to the Health Department, some data is available pertaining to these diseases. As part of the investigation process carried out by the staff of the MPHD for every case of hepatitis B and C reported as acute, some cases are confirmed to be chronic according to the case definition as described by CDC. [See Glossary for definition.] Although these numbers may not be inclusive of all cases of these diseases in the community, they may give a general perspective of the presence of the diseases in Nashville.

Figure 144. Number of Cases Chronic Hepatitis B and C, Nashville, TN, 1998 - 2000

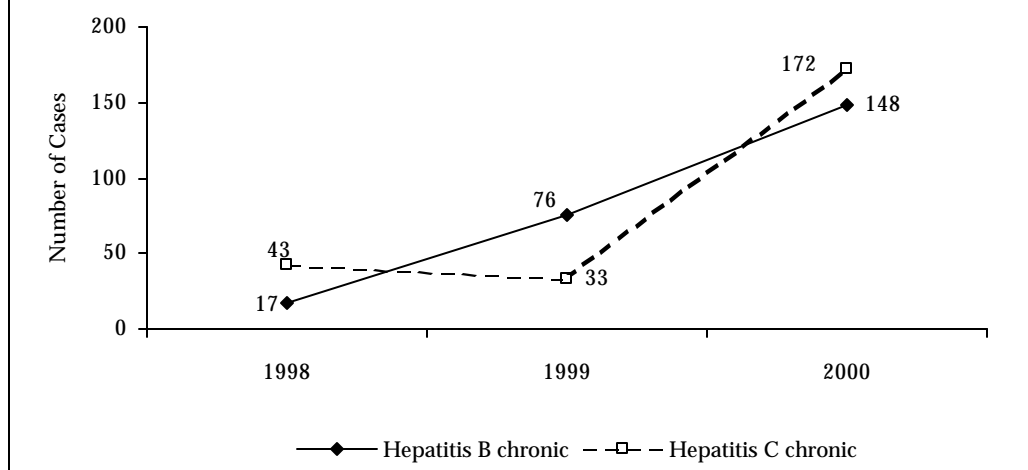
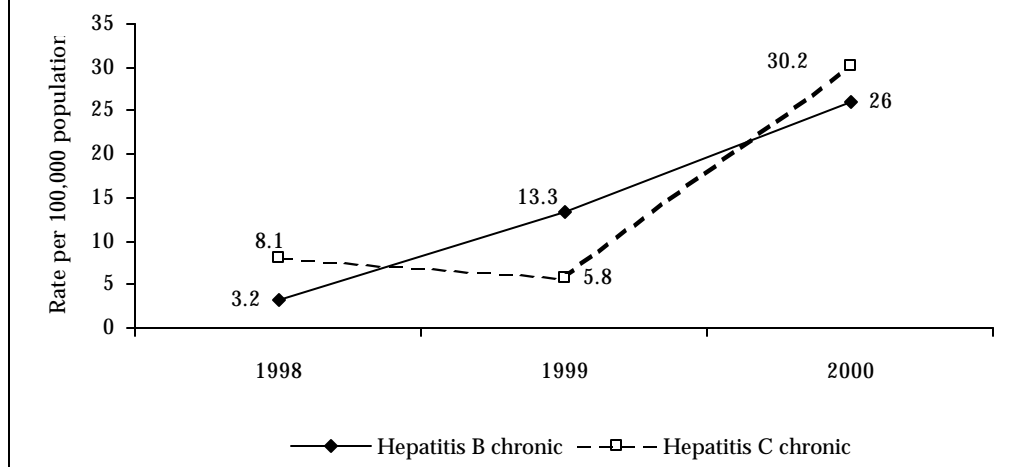


Figure 145. Incidence Rates for Chronic Hepatitis B and C, Nashville, TN, 1998 - 2000



Nashville experienced a 421.2% increase in identified chronic hepatitis C cases from 1999 to 2000 and a 94.7% increase in identified chronic hepatitis B cases in the same time period (Figure 144). Utilizing these numbers, Nashville's incidence rate for chronic hepatitis C in 2000 was 30.2 cases per 100,000 population. The incidence rate for chronic Hepatitis B in 2000 was 26 per 100,000 (Figure 145). Healthy People 2010 Developmental Objective 14-10 seeks to increase the proportion of chronic hepatitis C persons identified. Nashville would appear to be achieving this objective.

The CDC funds a Perinatal Hepatitis B Program for intensive case management of hepatitis B positive pregnant women. This program offers education, contact identification, testing, prophylaxis, and strict follow-up of the infants born to these mothers to assure that they receive correct and timely prophylaxis and post-vaccination blood work. The Perinatal Hepatitis B Program in Nashville is managed by the Division of Notifiable Disease Control/Immunization Promotion at MPHD.

References:

1. Chin J. *Control of Communicable Diseases Manual*. 17th Edition. Washington, DC: American Public Health Association; 2000.
2. Centers for Disease Control and Prevention. Hepatitis C: what clinicians and other health professionals need to know. Web based training program. 1998. Available at: http://www.cdc.gov/ncidod/diseases/hepatitis/c_training/edu/Info/info.htm. Accessed February 25, 2002.

Nashville experienced a 421.2% increase in identified chronic hepatitis C cases from 1999 to 2000 and a 94.7% increase in identified chronic hepatitis B cases in the same time period.

3.4.1.5 Vaccine-preventable Notifiable Diseases/Conditions

Vaccine-preventable notifiable diseases/conditions include:

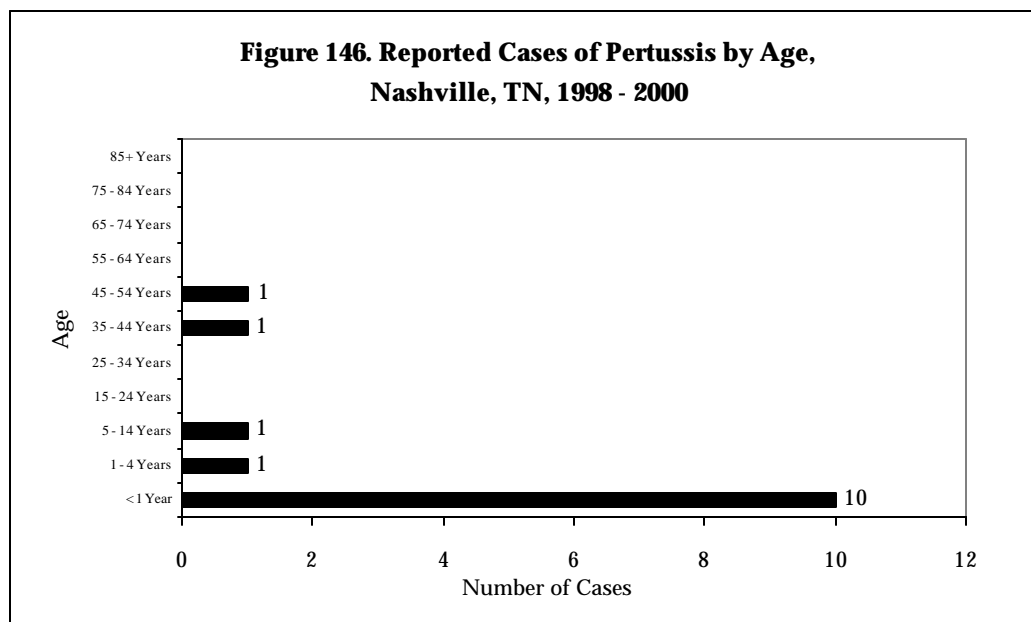
- diphtheria
- measles
- mumps
- pertussis
- poliomyelitis
- rubella
- influenza
- hepatitis A
- hepatitis B
- tetanus
- varicella deaths
- *Haemophilus influenzae* invasive disease

Background

The list of notifiable diseases preventable by vaccine includes measles, mumps, rubella, diphtheria, tetanus, poliomyelitis, influenza, hepatitis A, hepatitis B, varicella, *Haemophilus influenzae* type b, pertussis, and pneumococcal disease. Vaccination is an efficient and cost effective means of preventing infection. Vaccines prevent disease thereby eliminating the cost of treating illnesses. Also, vaccination decreases the number of susceptible persons in the community thereby reducing the circulation of infectious organisms and reducing the risk to persons in the community who are not vaccinated.

Findings

From 1998 to 2000, there were 14 cases of pertussis reported in Nashville. The incidence of pertussis nationwide has declined since the 1940s when pertussis vaccines were introduced. However, since 1980, the incidence rate has risen. Infants and children experience the highest rates of pertussis, and the rates for these age groups have not risen since 1993. However, nationwide the incidence among adolescents and adults has increased. This may be in part due to the fact that immunity may diminish as children grow into adolescence, and there is no licensed vaccine available for the older person. The increase may also be due in part to improved diagnosis and reporting of cases.¹ In Nashville, 10 of the reported 14 cases occurred in children less than 1 year of age (Figure 146).



Healthy People 2010 Objective 14-1 presents the goals for vaccine-preventable diseases. The 2010 goal for congenital rubella syndrome, diphtheria, *Haemophilus influenzae* in children under 5 years of age, measles, mumps, polio (wild virus type), rubella, and tetanus in persons aged 35 years and older is 0 cases. From 1998 to 2000, Nashville achieved this goal each year for congenital rubella syndrome, diphtheria, measles, polio, rubella, and tetanus. Nashville achieved the goal for mumps in 1999 and 2000. In 1999 and 2000, three of the 11 reported cases of *Haemophilus influenzae* invasive disease were in children under the age of five. Reported cases of pertussis increased from 1998 (2 cases) to 1999 (6 cases) and remained the same for 2000 (6 cases). However, the number of these cases who were under 7 years of age, the Healthy People 2010 Objective 14-1 target age group, increased yearly, from two cases in 1998 to six cases in 2000.

In 2000, Nashville ranked first compared to Memphis, Knoxville, and Chattanooga in number of cases and incidence per 100,000 of pertussis. Nashville's incidence rate of 1.1 was also above the 0.7 rate of Tennessee. Nashville's rate per 100,000 population was equal to or below the U.S. provisional rate for each of the selected diseases (Table 42).

Table 42. Comparison of Numbers and Incidence Rates for Selected Vaccine-preventable Diseases, Nashville, Memphis, Knoxville, Chattanooga, Tennessee, and U.S.*, 2000

Area	Measles		Mumps		Pertussis		Rubella	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Nashville	0	0.0	0	0.0	6	1.1	0	0.0
Memphis	0	0.0	1	0.1	1	0.1	0	0.0
Knoxville	0	0.0	0	0.0	4	1.0	1	0.3
Chattanooga	0	0.0	0	0.0	0	0.0	0	0.0
Tennessee	0	0.0	2	0.0	41	0.7	1	0.0
U.S.	81	0.0	323	0.1	6,755	2.4	152	0.1

*U.S. data provisional taken from MMWR, January 5, 2001/Vol.49/Nos.51&52. Rate calculated using 2000 census population.

Discussion

The Metropolitan Public Health Department provides services to monitor immunization levels in the community, promote immunization awareness, and investigate reports of vaccine-preventable diseases. Daycare and school immunization records are audited for adherence to the vaccine schedule and completion of the appropriate immunization series. Parents of infants born and residing in Davidson County receive notices reminding them of when immunizations are due. Each suspected case of a vaccine-preventable disease is investigated, contacts identified, and appropriate treatment provided.

MPHD offers computerized immunization assessments to public and private physician practices. These assessments pinpoint problem areas in vaccine delivery so that, when necessary, appropriate strategies to improve immunization levels can be developed and implemented.

Reference:

1. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Preventing emerging infectious diseases. a strategy for the 21st century [online]. 1998. Available at: <http://www.cdc.gov/ncidod/emergplan/planrequest.htm>. Accessed February 13, 2002.

The Metropolitan Public Health Department provides services to monitor immunization levels in the community, promote immunization awareness, and investigate reports of vaccine-preventable diseases.

3.4.1.6 Vector-borne Notifiable Diseases/Conditions

Background

Vector-borne notifiable diseases/conditions include:

- arboviral encephalitis
- ehrlichiosis
- Lyme disease
- malaria
- Rocky Mountain Spotted Fever

Vector-borne diseases are transmitted to humans and animals by blood-feeding arthropods, such as mosquitoes and ticks. These notifiable diseases include arboviral encephalitis, ehrlichiosis, Lyme disease, malaria, and Rocky Mountain Spotted Fever. Lyme disease accounts for 95% of all vector-borne diseases in the U.S. More than 145,000 cases have been reported to the CDC since nationwide surveillance began in 1982. The overall incidence rate in the U.S. is about 5 per 100,000 population, but Lyme disease is considered to be underreported.¹ The cost for treatment of Lyme disease is significant. Lyme disease diagnosed and treated in the early stages has a cost estimated at \$74 in direct medical costs. However, if diagnosis and treatment are delayed, complications such as meningitis, heart abnormalities, and chronic arthritis may develop. Treatment of these complications of Lyme disease may result in costs from \$2,228 to \$6,724 per patient in the first year alone.²

Findings

As is the case nationwide, Lyme disease was the most frequently reported vector-borne disease in Nashville. Ehrlichiosis and Rocky Mountain Spotted Fever, also tick-borne diseases, were the second and third most frequently reported vector-borne diseases from 1998 to 2000. Six cases of malaria, a mosquito-borne disease, were also reported in Nashville over the three-year period. No cases of arboviral encephalitis were reported in Nashville during this period. Arboviruses are transmitted when infected mosquitoes bite and infect susceptible humans. Once in the bloodstream, the viruses multiply and can cause inflammation of the brain, encephalitis. West Nile encephalitis became a concern in 1999, when 62 cases of the disease and 7 deaths occurred in the New York area. Prior to this time, West Nile virus was found only in Africa, Eastern Europe, West Asia, and the Middle East.³

The Healthy People 2010 Objective 14-8 pertains to the reduction of Lyme disease in the areas of the country where the disease is endemic. Nashville's incidence per 100,000 population fell from 1.2 in 1999 to 0.5 in 2000. Please see the Appendix for more information pertaining to Healthy People 2010 objectives.

Comparison of vector-borne diseases between Nashville and the other three largest metropolitan areas is seen in Table 43. In 2000, Nashville ranked first in incidence of ehrlichiosis and malaria. Memphis ranked first for Rocky Mountain Spotted Fever; Chattanooga ranked first for Lyme disease; and Knoxville, with 7 cases of California encephalitis, ranked first for arboviral encephalitis. Nashville's rate for malaria, 0.7, was higher than the Tennessee rate of 0.2. Provisional U.S. 2000 data was available only for Lyme Disease and malaria. Nashville ranked above the U.S. provisional incidence rate for malaria.

Table 43. Comparison of Numbers and Incidence Rates of Selected Vector-borne Diseases, Nashville, Memphis, Knoxville, Chattanooga, Tennessee, and U.S.*, 2000

Area	Ehrlichiosis		Lyme Disease		Rocky Mountain Spotted Fever		Malaria		Arboviral encephalitis-California	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Nashville	4	0.7	3	0.5	2	0.4	4	0.7	0	0.0
Memphis	0	0.0	1	0.1	5	0.6	3	0.3	2	0.2
Knoxville	1	0.3	1	0.3	2	0.5	1	0.3	7	1.8
Chattanooga	0	0.0	3	1.0	1	0.3	0	0.0	0	0.0
Tennessee	46	0.8	28	0.5	56	1.0	13	0.2	19	0.3
U.S.	NA**		13,309	4.7	NA		1,288	0.5	NA	

*U.S. data provisional taken from MMWR, January 5, 2001/Vol.49/Nos.51&52. Rate calculated using 2000 census population.

**Not available

Discussion

Ninety percent of reported Lyme disease in the past decade occurred in ten states in the northeast and upper Midwest U.S. Lyme disease is transmitted through the bite of ticks infected with *Borrelia burgdorferi*, primarily *Ixodes scapularis*. In about 90% of people infected with Lyme disease, the first manifestation is a red, expanding “bull’s-eye” rash, erythema migrans.⁴ A rash similar to erythema migrans has been identified in persons living in the southeastern and south-central states following the bite of the lone star tick, *Amblyomma americanum*. This Lyme disease-like rash has been named Southern tick-associated rash illness (STARI). Skin biopsies taken from these patients do not grow *Borrelia burgdorferi*. Patients experience mild constitutional symptoms, and recover uneventfully.⁵ The CDC is obtaining samples from patients suspected of having STARI under an Institutional Review Board-approved investigational protocol.

References:

1. Centers for Disease Control and Prevention. Division of Vector-borne Infectious Diseases. Epidemiology of lyme disease [online]. 2001. Available at: <http://www.cdc.gov/ncidod/dvbid/lyme/epi.htm>. Accessed March 7, 2002.
2. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Preventing emerging infectious diseases. a strategy for the 21st century [online]. 1998. Available at: <http://www.cdc.gov/ncidod/emergplan/planrequest.htm>. Accessed February 13, 2002.
3. Centers for Disease Control and Prevention. Division of Vector-borne Infectious Diseases. Questions and answers about the west Nile virus [online]. 2001. Available at: <http://www.cdc.gov/ncidod/dvbid/westnile/q&a.htm>. Accessed March 7, 2002.
4. Chin, J. *Control of Communicable Diseases Manual*. 17th Edition. Washington, DC: American Public Health Association; 2000.
5. Craig A. “Lyme-like disease in Tennessee.” *Public Health Watch*. Vol5No3. Nashville, TN: Metropolitan Public Health Department; 2001.

3.4.1.7 Notifiable Diseases/Conditions as Possible Bioterrorism Threats

The diseases/conditions most often associated with bioterrorism include:

- anthrax
- plague
- Venezuelan Equine Encephalitis
- smallpox
- botulism
- Q fever
- Staph enterotoxin B pulmonary poisoning
- Viral Hemorrhagic Fever
- brucellosis
- Ricin poisoning
- tularemia

Background

The diseases most often associated with bioterrorism include anthrax, plague, Venezuelan Equine Encephalitis, smallpox, botulism, Q Fever, Staph enterotoxin B pulmonary poisoning, Viral Hemorrhagic Fever, brucellosis, Ricin poisoning, and tularemia. Although these diseases/conditions are most often mentioned as bioterrorism threats, a biological agent does not have to be genetically engineered to be resistant to all known vaccines/drugs or highly contagious in order to be an effective terrorist weapon. In 1984 in The Dalles, Oregon, members of a religious commune successfully carried out a terrorist act using a common salmonella strain that was not lethal or contagious and was responsive to antibiotics. Over 700 people in the community were infected as a result of the deliberate contamination of salad bars in at least 10 restaurants with salmonella typhimurium.¹

Findings

No confirmed cases of notifiable diseases/conditions most often associated with bioterrorism were reported in Nashville from 1998 to 2000. Metropolitan Public Health Department has been involved in planning for a bioterrorist event since 1999. The plan was submitted to the Federal Government in September, 2000. Measures for active surveillance continue to be enhanced and training of MPH staff continues in order to successfully facilitate mobilization in the event of a bioterrorist act in Nashville.²

Discussion

Biological terrorism may not be immediately obvious. A small outbreak of illness could be an early warning of a more serious attack. Indications of biological terrorism could include more visits to physician offices, increased visits to emergency rooms, increased hospital admissions, increased antibiotic prescriptions filled by pharmacists, or increased calls to 911. To address the insidious threat of biological terrorism will require the combined efforts of all members of the community. The Metropolitan Public Health Department has developed a 911 syndrome surveillance system to observe for unusual or increased calls pertaining to specific symptoms. A daily monitoring system for certain notifiable diseases has also been established to look for sudden increases or changes in the trends of certain notifiable diseases.

References:

1. Torok TJ, Tauxe RV, Wise RP, Livengood JR, Sokolow R, Mauvais S, Birkness KA, Skeels MR, Horan JM, Foster LR. A large community outbreak of salmonellosis caused by intentional contamination of restaurant salad bars. *JAMA*. 1997; Aug 6;278 (5):389-95.
2. Trotter P. Bioterrorism: the role of the Metropolitan Health Department. *Public Health Watch*. Vol5No1. Nashville, Tennessee: Metropolitan Public Health Department; 2001.

Related Indicators

Vaccine-preventable
notifiable diseases/
conditions

3.4.2 Adult Influenza and Pneumococcal Vaccinations

Background

The national Advisory Committee for Immunization Practices (ACIP) recommends adults aged 50 and older, especially those aged 65 and older and individuals aged 6 months and older with certain chronic medical conditions, receive the influenza vaccine annually¹. ACIP also recommends adults aged 65 and older and individuals with certain chronic medical conditions receive a one-time dose of pneumococcal polysaccharide vaccine (PPV)². The U.S. Department of Health and Human Services has set national 'Healthy People' targets for influenza and PPV vaccination. The Healthy People targets calls for 80% of adults aged 65 and older to receive annual influenza vaccination and a one-time dose of PPV by year 2000, and 90% of adults aged 65 and older to be vaccinated by 2010 (Objective 14-29).³

On average, influenza alone is responsible for 20,000 deaths and 110,000 hospitalizations every year in the U.S. During severe flu seasons, influenza may account for as many as 40,000 deaths and 300,000 hospitalizations nationally. Annual influenza vaccination can prevent illness in between 70% and 90% of vaccinated healthy adults <65 years old.¹ More importantly, although the vaccine is not as effective at preventing illness among the elderly and among individuals with chronic medical conditions, the vaccine is very effective in preventing more serious secondary complications such as pneumonia, which can result in hospitalization and/or death.

Additional Data

Appendices
pages D-73 - D-75

Each year, pneumococcal disease results in 500,000 cases of pneumonia, 50,000 cases of bacteremia, 3,000 cases of meningitis and as many as 40,000 deaths. It is estimated that 50% of these deaths can be prevented with the use of PPV which is considered safe and effective at reducing invasive pneumococcal disease among adults aged 65 and older and those under 65 with certain medical conditions.²

There are two data sources from which we can obtain estimates for adult vaccination coverage in Nashville: the 1998 adult Behavioral Risk Factor Surveillance Survey (BRFSS) and year 2000 Medicare billing records. Since these data only provide rough estimates of vaccination rates, it is important to remember what we report may be underestimates or overestimates of the true adult vaccination rates in Nashville. Nonetheless, Medicare billing data and BRFSS estimates can still provide a general overview of the status of adult vaccination in Nashville.

Findings

1998 BRFSS

The most recent BRFSS data available for Nashville is from 1998. In 1998, BRFSS respondents were asked two questions related to immunization: "During the past 12 months, have you had a flu shot" and "Have you ever had a pneumonia vaccination?" Of all the respondents, only 35% reported receiving the influenza vaccine (Figure 147). Among respondents aged 65 and older, the percentage reporting influenza vaccination was 67%. Based on the BRFSS results, there appears to be a disparity in influenza vaccination rates between men and women. Sixty-six percent (66%) of men aged 65 and older reported receiving the influenza vaccine in 1998, but only 37% of women did. A racial disparity is also evident, with a smaller proportion of blacks reporting vaccination than whites (45% compared to 71% among respondents aged 65 and older). Pneumococcal vaccination rates were lower than influenza vaccination rates.

Data Sources

- Metro Public Health Department: BRFSS
- Medicare

Only 50% of respondents aged 65 and older reported receiving a pneumonia vaccination (PPV) (Figure 148). There was no difference in the pneumococcal vaccination rate between men and women, however racial differences were again apparent. Fifty-four percent (54%) of white respondents, but only 32% of blacks aged 65 and older reported receiving the PPV vaccine by 1998.

Figure 147. Percent of BRFSS Respondents Who Received Influenza Vaccination, Nashville, TN, 1998

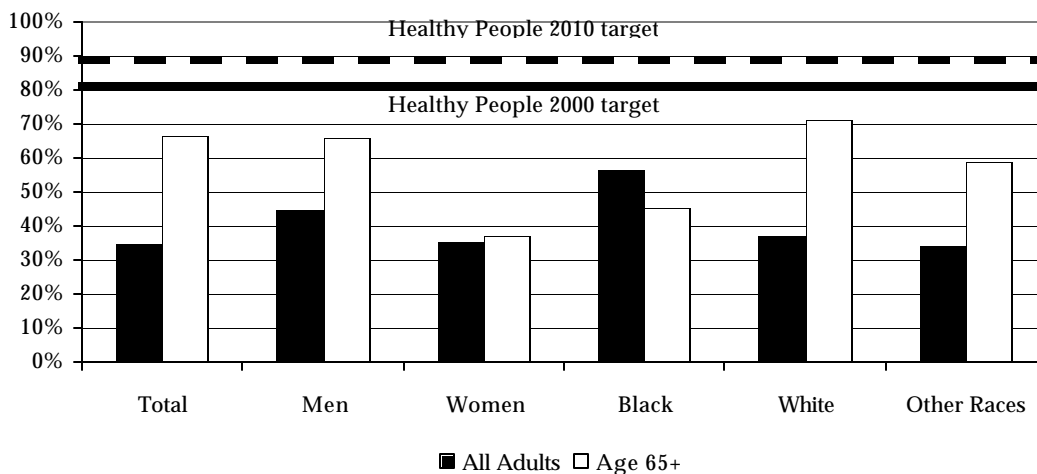
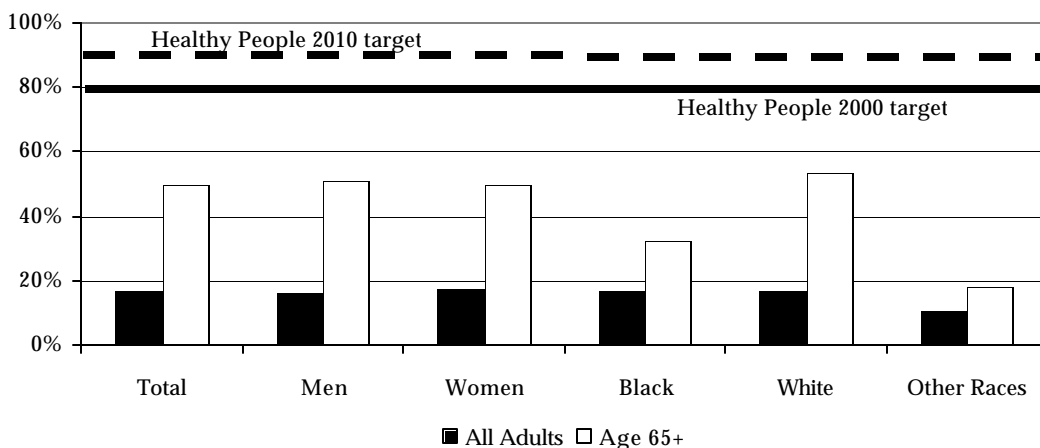
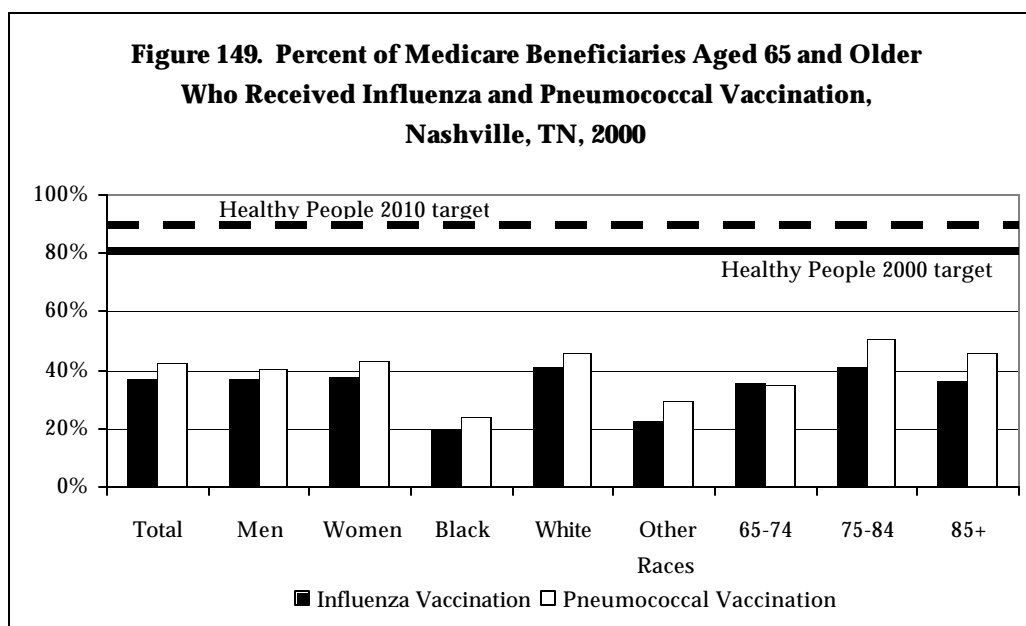


Figure 148. Percent of BRFSS Respondents Who Received Pneumococcal Vaccination, Nashville, TN, 1998



2000 Medicare

The Center for Medicare and Medicaid Services (CMS) collects information on influenza and pneumococcal vaccination of Medicare beneficiaries from billing records. This data shows that, similar to the BRFSS results, blacks have a lower vaccination rate than whites (Figure 149). In 2000, white Medicare beneficiaries aged 65 and older had influenza and pneumococcal vaccination rates that were nearly double the rates among blacks. Older age groups tended to have higher vaccination rates than younger age groups (Figure 148). Unlike the BRFSS data, there was no gender disparity apparent in the Medicare billing data (Figure 148). When the Medicare data were examined by zip code regions, we found that the zip codes with the largest black populations tended to have the lowest vaccination rates, but that blacks living in zip codes with large white populations tended to have higher vaccination rates than other blacks. The same was true for whites living in predominately black areas – their vaccination rates were lower and coincided with the majority (blacks). (See Maps 1 - 4.)

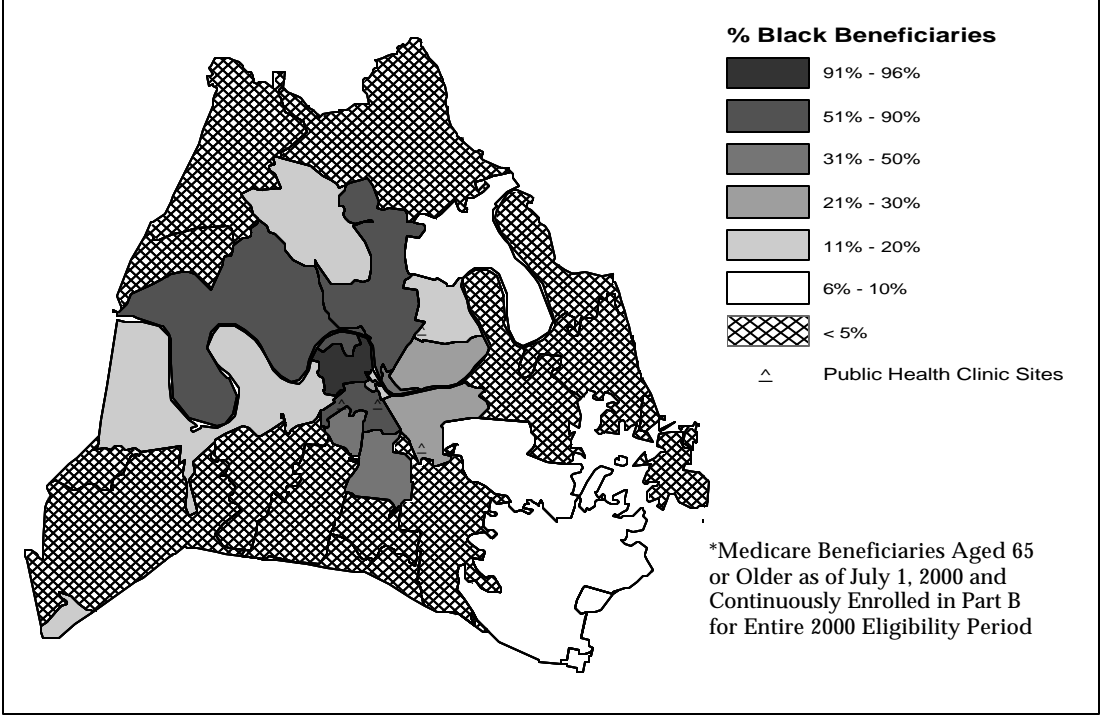


Over time, vaccination rates are expected to increase due to improved delivery systems and increased community knowledge about the benefits of these vaccines.

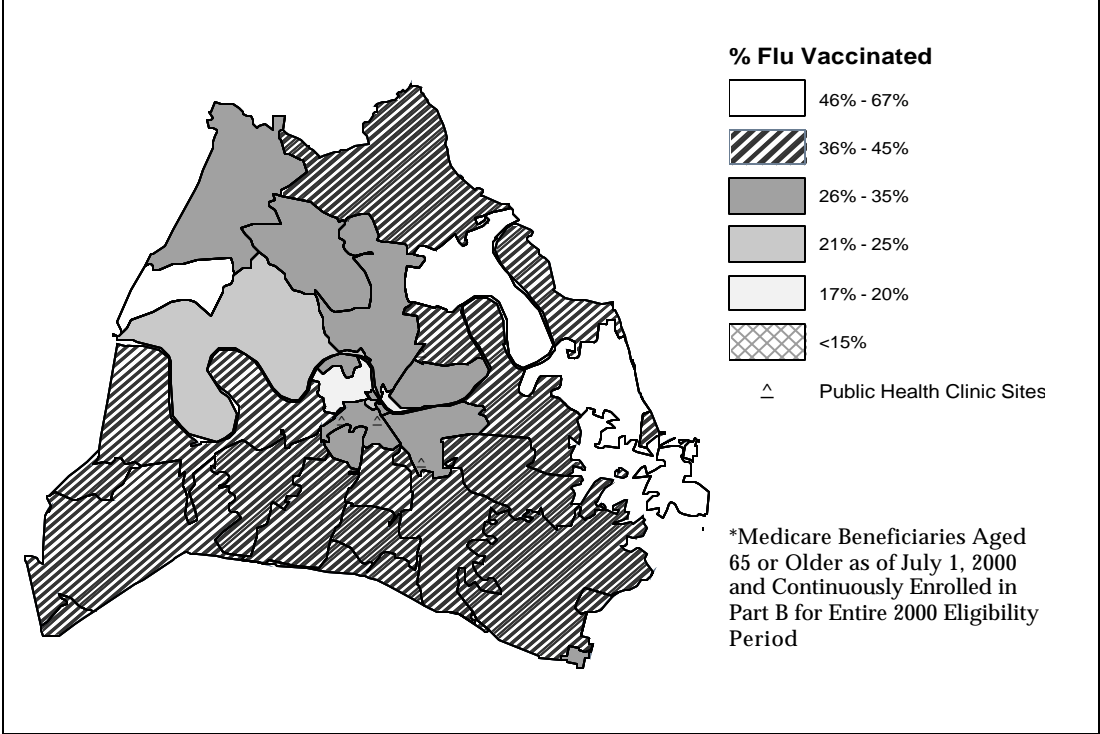
Pneumococcal vaccination rates increased three percentage points from 1999 to 2000 and there is hope that this trend will continue (Table 44). Influenza vaccination rates declined in 2000 compared to 1999, likely resulting from the delay in the availability of the influenza vaccine in 2000⁴.

Among respondents aged 65 and older, the percentage reporting influenza vaccination was 67%. Only 50% of respondents aged 65 and older reported receiving a pneumonia vaccination.

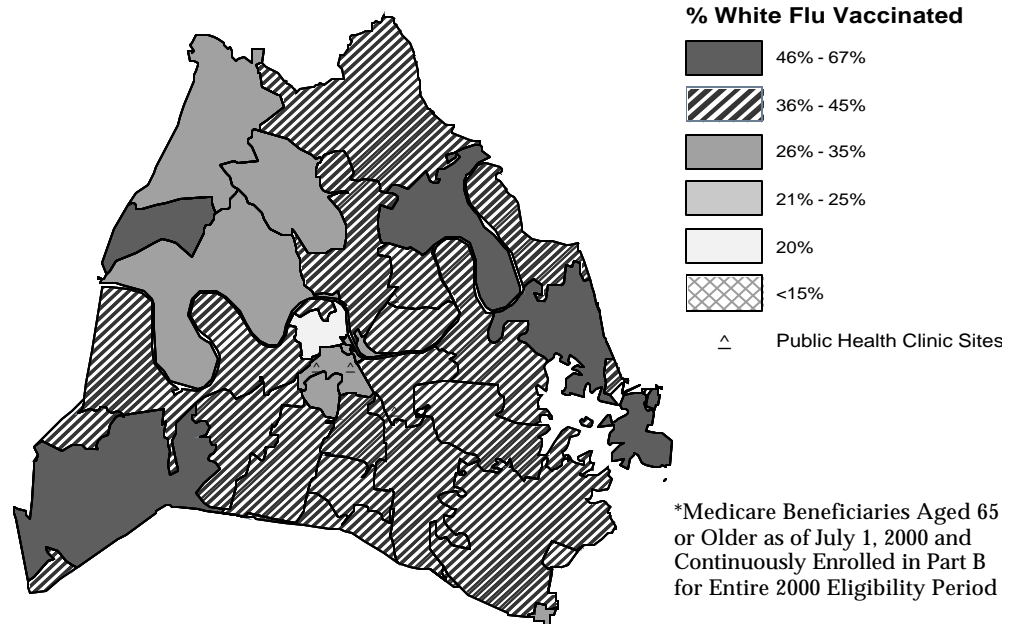
Map 1. Percentage of Black Medicare Beneficiaries Aged 65 and Older by Zip Code, Nashville, TN, 2000



Map 2. Percentage of Medicare Beneficiaries Aged 65 and Older Who Received Influenza Vaccine, Nashville, TN, 2000



Map 3. Percentage of White Medicare Beneficiaries Aged 65 and Older Who Received Influenza Vaccine by Zip Code, Nashville, TN, 2000



Map 4. Percentage of Black Medicare Beneficiaries Aged 65 and Older Who Received Influenza Vaccine by Zip Code, Nashville, TN, 2000

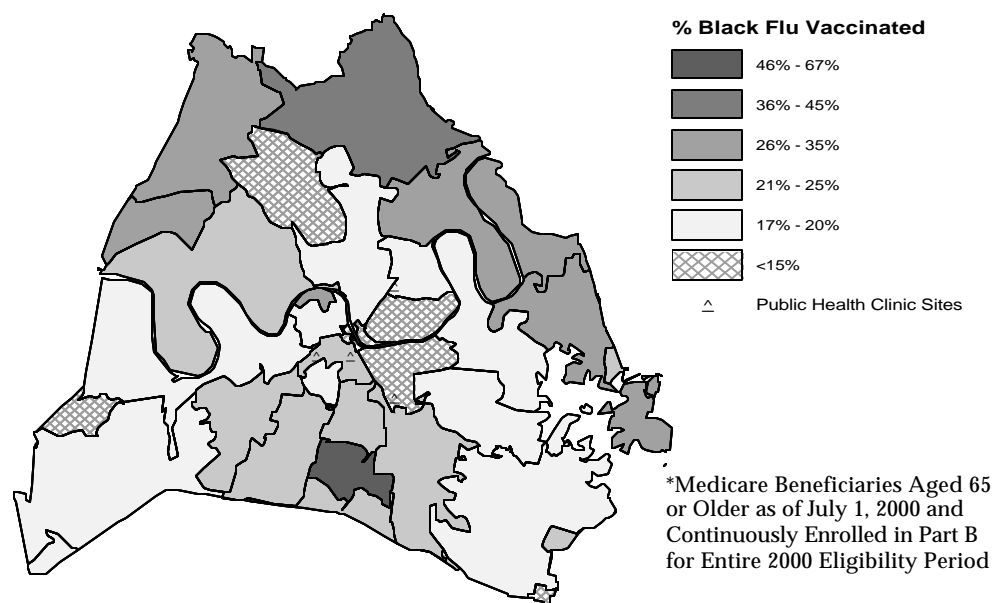


Table 44. Percent of Medicare Beneficiaries Aged 65 and Older Who Received Influenza and Pneumococcal Vaccinations, Nashville, 1999-2000, Tennessee and U.S., 2000*

Vaccination	Nashville 1999	Nashville 2000	Tennessee 2000	U.S. 2000
Influenza	47%	37%	42%	37%
Pneumococcal	40%	43%	41%	37%

* Data collected by the Center for Medicare and Medicaid Services (CMS) and supplied by the Tennessee Peer Review Organization (PRO), the Center for Healthcare Quality

Comparing Nashville to Tennessee and the U.S.

The Nashville self-reported immunization rates for adults age 65 and older were very similar to those from the Tennessee BRFSS and the composite U.S. BRFSS data (Table 45). For influenza, there was essentially no difference from the local to state level or the local to national level. For pneumococcal vaccination, the Nashville rate was about five percentage points below the national average and the Tennessee rate.

Table 45. Percent of BRFSS Respondents Aged 65 and Older Who Received Influenza and Pneumococcal Vaccinations, Nashville, 1998, Tennessee and U.S., 1999

Vaccination	Nashville 1998	Tennessee 1999	U.S. 1999*
Influenza	67%	66%	67%
Pneumococcal	50%	54%	55%

*U.S. data reflects the median percent from the 50 states, District of Columbia, and Puerto Rico

The Medicare billing data show that the influenza vaccination rate in Nashville is slightly lower than the Tennessee rate, but is similar to the rate for the U.S. (Table 44). Unlike the results from the BRFSS, Medicare data show that the pneumococcal vaccination rate in Nashville is higher than the rate for Tennessee and the U.S.

Discussion

According to the available data sources, Nashville had not met the Healthy People goal for influenza and pneumococcal vaccination of 80% among adults aged 65 and older by year 2000. A great deal of effort is needed in Nashville to achieve the Healthy People 2010 goal for influenza and pneumococcal vaccination of 90% for adults aged 65 and older. The vaccines for both influenza and pneumococcal disease are covered by Medicare Part B, thus removing cost as a barrier for most residents aged 65 and older. To further expand access to these vaccinations, each year in the late fall, MPH D offers a vaccination clinic to provide Nashville residents with free influenza and pneumococcal vaccines. MPH D has also partnered with pharmacists in those areas of the city with the lowest vaccination rates to make pneumococcal vaccines more readily available to the community.

References:

1. Centers for Disease Control and Prevention. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices. *Morbidity and Mortality Weekly Report*. 2002; 51(RR-3): 1-31.
2. Centers for Disease Control and Prevention. Prevention of pneumococcal disease: recommendations of the Advisory Committee on Immunization Practices. *Morbidity and Mortality Weekly Report*. 1997; 46(RR-8): 1-24.
3. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office; November 2000.
4. Centers for Disease Control and Prevention. Delayed supply of influenza vaccine and adjunct ACIP influenza vaccine recommendations for the 2000—01 influenza season [Notice to readers]. *Morbidity and Mortality Weekly Report*. 2000; 49(27): 619-622.

According to the available data sources, Nashville had not met the Healthy People goal for influenza and pneumococcal vaccination of 80% among adults aged 65 and older by year 2000.

Related Indicators

- Sexual behavior
- Substance abuse and illicit drug use
- Poverty level
- Lack of health insurance

Additional Data

Appendices
pages D-76 - D-81

Data Sources

- Metro Public Health Department
- Tennessee Department of Health

3.4.3 Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) are communicable diseases spread primarily by sexual activity. Despite the preventable and often treatable nature of STDs, they continue to be a significant public health problem in Nashville and across the country. Rates of specific STDs are calculated by dividing the total number of cases by the population at risk.

The rates of various STDs in a community are important community health indicators because they are associated with a variety of factors, including poverty, substance abuse, access to health care, and responsible sexual behaviors. If left undiagnosed and untreated, these illnesses can have serious long-term health consequences, such as infertility, fetal and infant health problems, cancer, and death. In addition, certain STDs can place individuals at greater risk of contracting HIV once exposed.

To address the threat of STDs in Nashville, MPHD has a number of programs in place designed to identify, treat, educate, and prevent transmission of STDs. MPHD conducts disease surveillance and reporting. This allows tracking of STD trends over time and in various populations, and helps to target resources to those populations most at risk. The STD clinic at Lentz Public Health Center provides testing and treatment for STDs such as syphilis, gonorrhea, chlamydia and trichomoniasis. Confidential HIV testing is also provided. Health workers at MPHD provide counseling and education about STDs, how they are transmitted and how to prevent infection, both to clients in the clinic setting, and in the community. When an individual is positive for an STD, MPHD provides partner notification and treatment. This service is important because it can prevent and treat illness in individuals who are carrying, or may have been exposed to STDs, but who have not yet been diagnosed. It also plays a crucial role in interrupting and preventing further disease transmission in the community¹.

The information provided here refers to diseases that are reportable by law to MPHD. These diseases include chlamydia, gonorrhea, syphilis, HIV and AIDS. Among the other STDs that have an impact on the overall health of our community but are not reportable by law are herpes, genital warts (HPV), and trichomoniasis. In addition, reported rates are most likely an underestimate of the true rate of disease in the community because infected individuals may fail to seek diagnosis and treatment for their illness, and physicians may neglect to report all STD cases to the health department. This makes STD rates sensitive to improvements (and declines) in the quality of public health surveillance activities.

Reference:

1. Rogers B, Huang J, Horner N, Perkey B. *Sexually Transmitted Diseases in the 1990's in Davidson County, Tennessee*. Nashville, TN: Metropolitan Public Health Department of Nashville and Davidson County, Division of Epidemiology; October, 2000.

MPHD has a number of programs in place designed to identify, treat, educate, and prevent transmission of STDs.

3.4.3.1 Chlamydia

Background

Chlamydia trachomatis is a bacterial infection, primarily spread by sexual activity. Chlamydia is easily treatable with antibiotics; however, infected individuals often do not know they have chlamydia because the majority of cases (75% in women; 50% in men) are asymptomatic (without symptoms).¹ In women, if left untreated, chlamydia may lead to Pelvic Inflammatory Disease (PID), an important cause of infertility, chronic pelvic pain, and ectopic pregnancies.

In Nashville, there were 2,403 cases of chlamydia reported to the MPHD in 2000.

The Centers for Disease Control and Prevention (CDC) recommends annual screening for all women, age 20 and younger, and also for women over 20 with risk factors for infection such as new or multiple sex partners, or lack of barrier contraception. In addition, all women with cervical infections and all pregnant women should be tested.² The national Healthy People 2010 goal (25-1) towards reducing chlamydia morbidity is to reduce the proportion of adolescents and young adults, attending family planning and STD clinics that are infected with chlamydia to 3.0%.³

In Nashville, we do not have a good measure of the number of young adults attending family planning and STD clinics. Therefore, in this report, the rate of chlamydia overall, and among the target age group (15-24 year olds) are calculated from disease surveillance data for all areas (local, state and national). These rates differ from the national Healthy People measure because they include in the denominator individuals from the general population who are presumably at lower risk of infection than those who would visit a STD or family planning clinic. Because of this, we would expect rates of disease based on surveillance data to be much lower in comparison to rates calculated from data collected at STD and family planning clinics.

Findings

In Nashville, there were 2,403 cases of chlamydia reported to the MPHD in 2000. Rates of chlamydia have been increasing in Nashville since the early 1990's.⁴ Between 1995

Figure 150. Chlamydia Rates by Race and Gender, Nashville, TN, 1995 - 2001

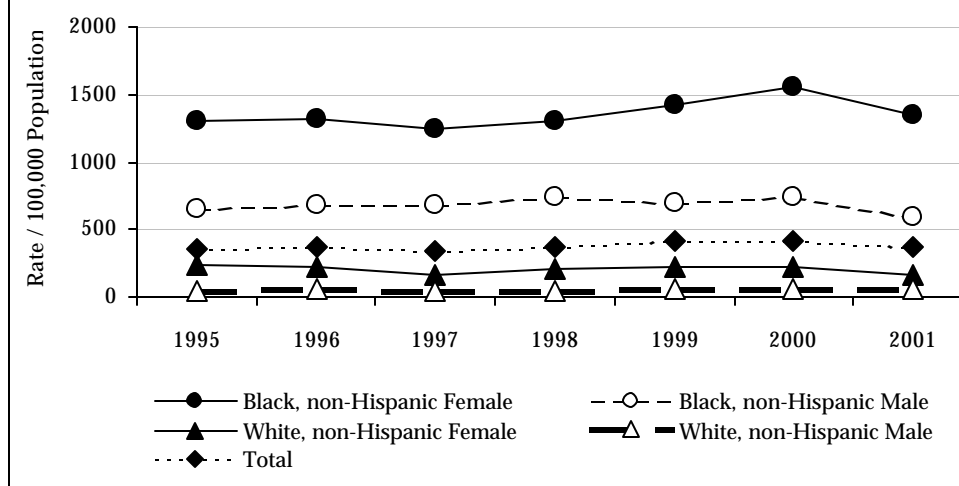
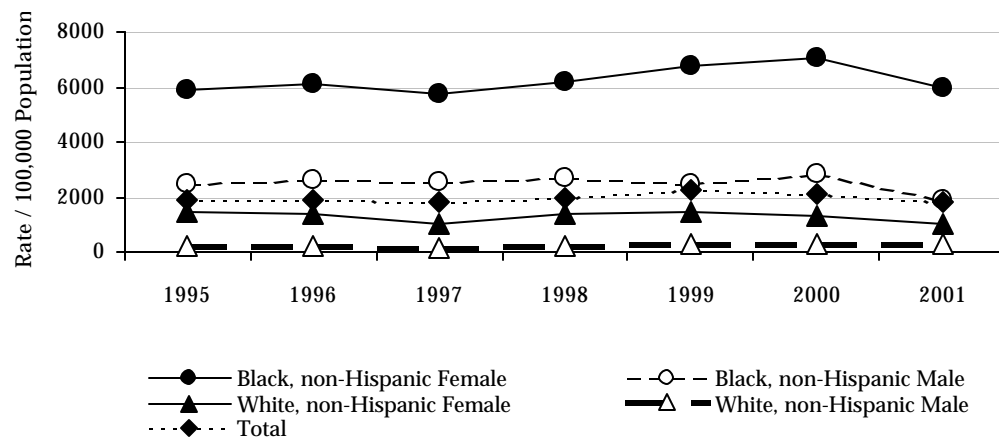


Figure 151. Chlamydia Rates among Young Adults Aged 15-24 by Race and Gender, Nashville, TN, 1995 - 2001



Nationally, chlamydia is the most commonly reported notifiable disease, with a rate of 258 per 100,000 population in 2000.

Table 46. Chlamydia Rates by Subgroup, Nashville, TN, 2000

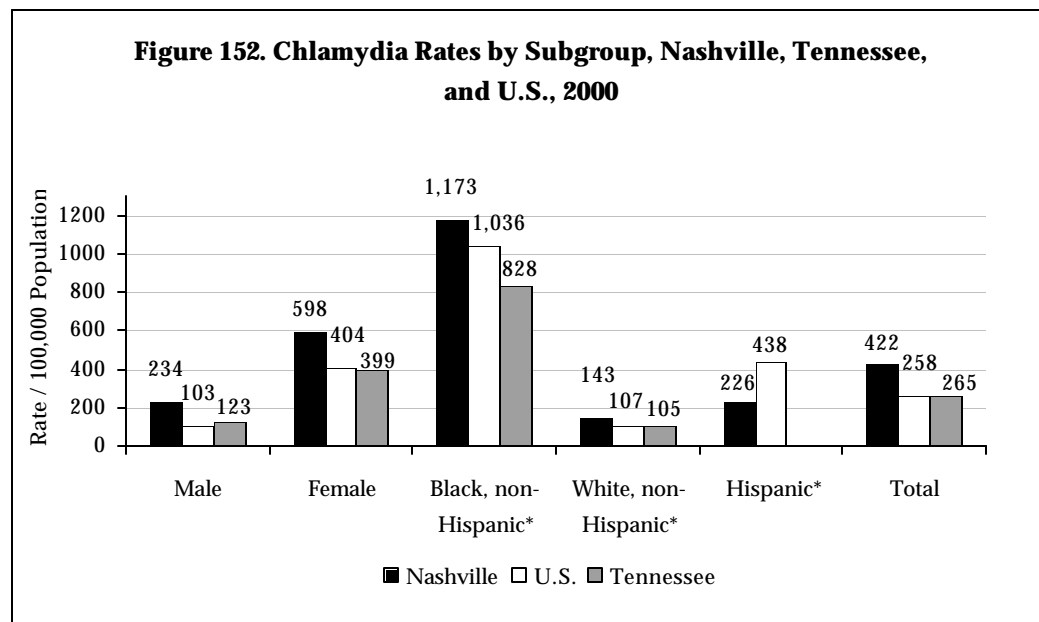
	Chlamydia Rate/100,000 Population		
	Both Genders	Males	Females
TOTAL	422	234	598
RACE			
Black or African American	1,181	744	1,561
White	146	61	226
Other	99	67	139
Asian or Pacific Islander	73	ψ	ψ
American Indian or Alaska Native	ψ	ψ	ψ
ETHNICITY			
Hispanic or Latino	226	94	433
Not Hispanic or Latino	421	240	586
Black or African American	1,173	735	1,553
White	143	63	218
Other	168	83	277
AGE			
15-24	2,127	988	3,257
Black or African American	5,120	2,860	7,080
White	808	250	1,364
Other	253	122	440
Hispanic or Latino	602	205	1,372
Not Hispanic or Latino	2,206	1,074	3,268
Black or African American	5,095	2,821	7,067
White	811	267	1,338
Other	499	197	950
25-34	409	329	493
35-44	91	80	102

ψ Data are statistically unreliable.

and 2000, the rate of chlamydia in Nashville rose from 361 per 100,000 population in 1995 to 422 in 2000 (Figure 150). Among 15-24 year olds, the chlamydia rate rose from 1,866 in 1995, to 2,127 in 2000 (Figure 151). It is likely that these increases were due in part to increased screening and improved diagnostic testing, however, these factors probably do not account for all of the increases. Rates among women (598) were much higher than among men (234), most likely due to the asymptomatic nature of the infection and because women are screened more frequently. When examined by race, rates for whites remained low and relatively constant or decreased, while rates among blacks increased. Black females, aged 15-24, had the highest rate of chlamydia (7,080), whereas white females aged 15-24 had a rate of only 1,364 (Table 46). Preliminary data from 2001 suggests that chlamydia rates are finally on the decrease (Figures 150 and 151).

Comparing Nashville to Tennessee and the U.S.

Nationally, chlamydia is the most commonly reported notifiable disease, with a rate of 258 per 100,000 population in 2000⁵. This is a large increase from 190 in 1995⁶. In 2000, Tennessee ranked 18th in the nation for reported cases of chlamydia⁶, with a rate of 265, up from 251 in 1995. Rates of disease in Nashville are higher than Tennessee or U.S. rates, however, Nashville is an urban center and rates are expected to be higher. Chlamydia rates are much higher among women than among men. In year 2000, rates among U.S. women (404) were approximately four times that of U.S. men (103)⁵. In Tennessee, the disparity between women (399) and men (123) was similar, however, the gender disparity in Nashville is much less pronounced. This could be an indication that Nashville is doing a good job of testing males for chlamydia, or that Nashville needs to improve screening efforts for women. There is also a large race disparity seen with chlamydia. U.S. blacks have a chlamydia rate ten times that of whites⁵. In Tennessee, and in Nashville, the racial disparity is large, although less pronounced



*Ethnicity information was not available for Tennessee, therefore, rates by race for Tennessee are reported without taking ethnicity into account.

than the U.S. overall, with blacks having a rate approximately 8 times higher than whites. Chlamydia rates among Hispanics fell in between the rates for blacks and whites, with a rate 50% higher than whites in Nashville, and more than four times higher than whites in the U.S. overall (Figure 152).

It is clear that chlamydia continues to be a serious health problem in Nashville.

Discussion

Since 1993, the federal government has provided funding for STD-related infertility prevention, with chlamydia screening and testing as a cornerstone of the project. In regions where screening has been fully implemented, great success has been demonstrated⁷. In addition, extremely accurate urine tests have been recently developed which will make chlamydia screening for men more convenient and less painful. As a result, reported rates in men may soon more closely mirror those among women⁸.

It is clear that chlamydia continues to be a serious health problem in Nashville. The lower reported rates of chlamydia among men compared to those among women suggest that many of the partners of infected women are not being screened or seeking treatment and are a continued transmission risk. With increased screening and the utilization of more user-friendly and accurate tests in the clinic setting, additional cases will be found and treated. Targeted screening for those most at risk (young black women aged 15-24) may further impact rates of disease.

References:

1. Centers for Disease Control and Prevention. National Center for HIV, STD and TB Prevention, Division of Sexually Transmitted Diseases. The Chlamydia Fact Sheet page. Available at: http://www.cdc.gov/nchstp/dstd/Fact_Sheets/chlamydia_facts.htm#N_1_. Accessed January 31, 2002.
2. Centers for Disease Control and Prevention. Recommendations for the prevention and management of Chlamydia trachomatis infections, 1993. *Morbidity and Mortality Weekly Report*. 1993; 42(RR-12); 1-42.
3. U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition, in Two Volumes)*. Washington, DC: January, 2000.
4. Rogers B, Huang J, Horner N, Perkey B. *Sexually Transmitted Diseases in the 1990's in Davidson County, Tennessee*. Nashville, TN: Metropolitan Public Health Department of Nashville and Davidson County, Division of Epidemiology; October, 2000.
5. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2000*. Atlanta, GA: U.S. Department of Health and Human Services. September; 2001.
6. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 1999*. Atlanta, GA: U.S. Department of Health and Human Services. September; 2000.
7. Scholes D, Stergachis A, Heidrich FE, Andrilla H, Holmes KK, Stamm WE. Prevention of pelvic inflammatory disease by screening for cervical chlamydial infection. *NEJM*. 1996; 34(21):1362-66.
8. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2000 Supplement, Chlamydia Prevalence Monitoring Project*. Atlanta, GA: U.S. Department of Health and Human Services; November, 2001.

3.4.3.2 Gonorrhea

Background

In Nashville in 2000, there were 2,404 cases of gonorrhea reported to the MPHD.

Gonorrhea is a sexually transmitted disease caused by the bacteria *Neisseria gonorrhoeae* and is an important public health concern. Similar to chlamydia, gonorrhea is a major cause of pelvic inflammatory disease because many women remain asymptomatic until complications occur.¹ There is also evidence that gonorrhea infections place individuals at higher risk of contracting HIV if exposed.²

Because many cases of gonorrhea are without symptoms, CDC recommends routine screening of women at high risk for STDs.¹ The national Healthy People 2010 goal (25-2) is to reduce new cases of gonorrhea to 19 per 100,000 population.³

Findings

In Nashville in 2000, there were 2,404 cases of gonorrhea reported to the MPHD. This represents a rate of 422 per 100,000 population. When examined by gender, the rate among men (503) was higher than among women (346). Black males aged 15-24 had the highest rate of disease in Nashville, with a rate of 4,718, nearly 20 times higher than white males in the same age group, and 47 times higher than white males overall (Table 47, Figure 153). After a slight increase between 1999 and 2000 (likely a result of increased surveillance), preliminary data for 2001 show the gonorrhea rate among black males aged 15-24 falling below the rate for women in the same age group to 2,762 (Figure 154). The rate among black males overall fell to 988 in 2001, the lowest level in more than a decade¹ (Figure 153).

Figure 153. Gonorrhea Rates by Race and Gender, Nashville, TN, 1995 - 2001

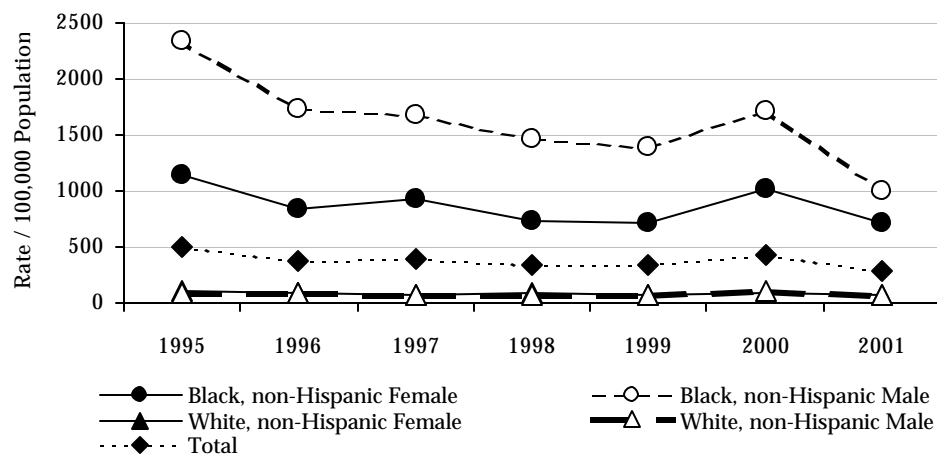


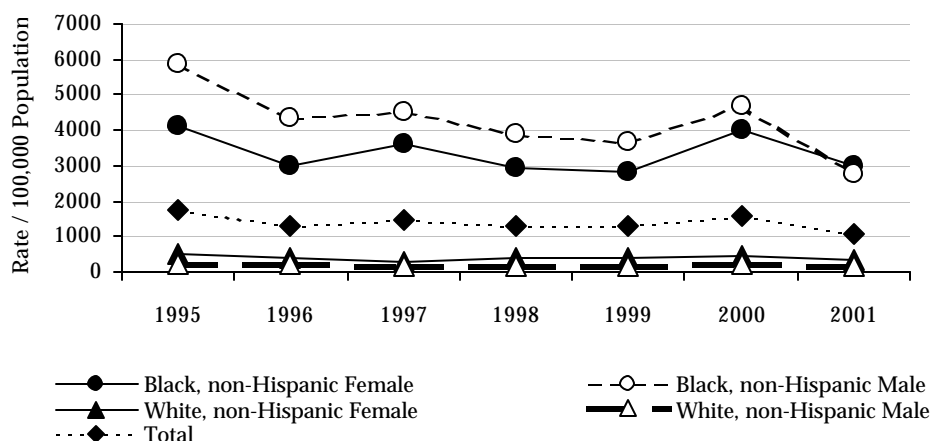
Table 47. Gonorrhea Rates by Subgroup, Nashville, TN, 2000

	Gonorrhea Rate/100,000 Population		
	Both Genders	Males	Females
TOTAL	422	503	346
RACE			
Black or African American	1,340	1,717	1,012
White	96	100	93
Other	37	49	22
<i>Asian or Pacific Islander</i>	ψ	ψ	ψ
<i>American Indian or Alaska Native</i>	ψ	ψ	ψ
ETHNICITY			
Hispanic or Latino	119	157	59
Not Hispanic or Latino	430	520	348
<i>Black or African American</i>	1,335	1,707	1,012
<i>White</i>	97	99	95
<i>Other</i>	79	ψ	ψ
AGE			
15-24	1,566	1,523	1,609
<i>Black or African American</i>	4,318	4,718	3,971
<i>White</i>	340	239	442
<i>Other</i>	108	122	88
<i>Hispanic or Latino</i>	226	ψ	ψ
<i>Not Hispanic or Latino</i>	1,657	1,656	1,658
<i>Black or African American</i>	4,322	4,707	3,989
<i>White</i>	346	234	454
<i>Other</i>	ψ	ψ	ψ
25-34	606	787	417
35-44	322	491	157

ψ Data are statistically unreliable.

Gonorrhea rates in Nashville are higher than Tennessee or U.S. rates.

Figure 154. Gonorrhea Rates Among Young Adults Aged 15-24 by Race and Gender, Nashville, TN, 1995 - 2001

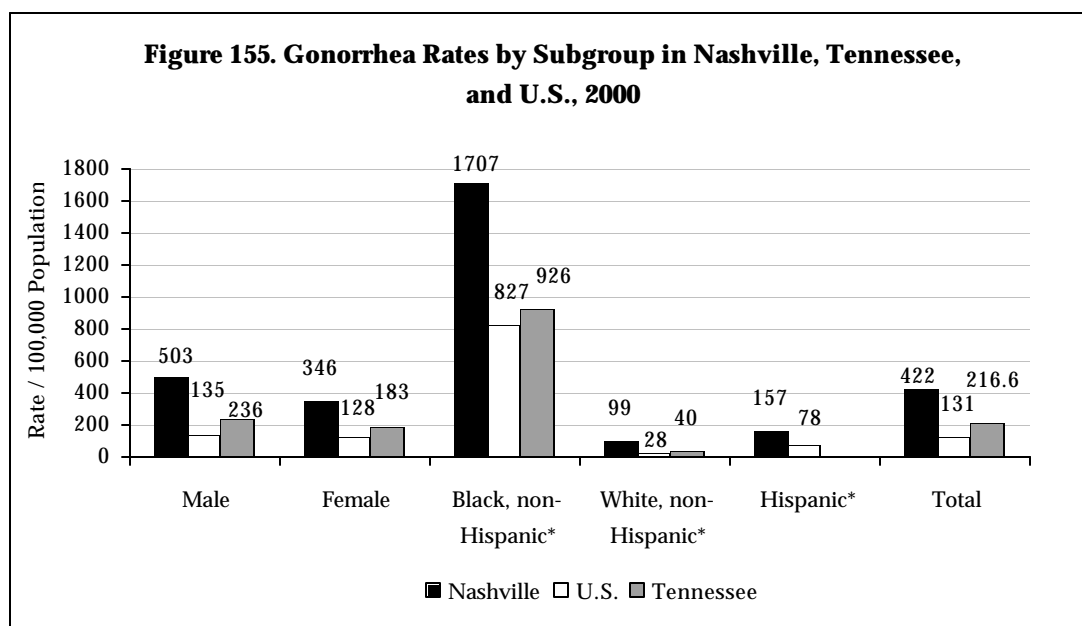


Comparing Nashville to Tennessee and the U.S.

The national rate of gonorrhea was 131 per 100,000 population in 2000.⁴ This represents a decrease from 150 in 1995,⁶ but an increase from 124 in 1996.² U.S. rates have been relatively steady at about 132 per 100,000 from 1998 to 2000.² In 2000, Tennessee ranked 7th in the nation² with an overall rate of 209. Gonorrhea rates in Nashville are higher than Tennessee or U.S. rates, however, Nashville is an urban center and rates are expected to be higher. As opposed to chlamydia rates, gonorrhea rates are higher among men than among women, most likely because men exhibit symptoms more frequently than do women. Among U.S. women in 2000, the rate was slightly lower (130) than among men (136), consistent with previous years. Similar to national rates of disease, gonorrhea rates among Tennessee and Nashville women have been consistently lower than rates among men over the past 5 years although the gender disparity is greater (Figure 154). There is also a racial disparity in gonorrhea rates. Blacks have consistently higher rates than whites in Nashville, Tennessee, and the U.S. The racial disparity is less pronounced in Nashville, where blacks have a rate 17 times that of whites, than in Tennessee or the U.S. where the rates are 23 and 29 times greater among blacks than among whites, respectively (Figure 155). Hispanics had a rate 50% higher than whites in Nashville, and nearly three times that of whites in the U.S. overall.

Discussion

As expected, Nashville has not met the national Healthy People objectives for the reduction of gonorrhea, in part because it is an urban center. However, targeting populations with the highest rates of disease in Nashville (blacks, especially men, and 15-24 year olds) will help bring local rates closer to national goals. The high rate of gonorrhea in Nashville indicates that this disease continues to be an important public health concern. The relative stability of gonorrhea rates over the past 3 years suggests that new prevention and control strategies may need to be implemented in order to reach those populations at highest risk of disease and to reduce rates even further.



*Ethnicity information was not available for Tennessee, therefore, rates by race for Tennessee are reported without taking ethnicity into account.

References:

1. Centers for Disease Control and Prevention. Sexually transmitted disease treatment guidelines 2002. *Morbidity and Mortality Weekly Report*. 2002; 51 (RR-6): 1-84.
2. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 1999*. Atlanta, GA: U.S. Department of Health and Human Services. September; 2000.
3. U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition, in Two Volumes)*. Washington, DC: January, 2000.
4. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2000*. Atlanta, GA: U.S. Department of Health and Human Services; September, 2001.

The high rate of gonorrhea in Nashville indicates that this disease continues to be an important public health concern.

3.4.3.3 Syphilis

Background

In Nashville in 2000, there were 200 cases of syphilis reported to MPHD. Syphilis rates in Nashville increased from 1995 - 1999 and are now on the decrease.

Syphilis is a sexually transmitted disease caused by the spirochetal bacterium, *Treponema pallidum*. Syphilis begins with an ulcer at the point of infection and if left untreated, can result in long-term effects such as neurological or cardiovascular damage. The genital ulcers caused by syphilis can facilitate the transmission of HIV, especially in populations with high rates of both HIV and syphilis. Pregnant women infected with syphilis are at risk for miscarriage and fetal death, and children born to mothers infected with syphilis are at risk for birth defects and other disorders.¹

Because syphilis is easily detectable with a blood test, is easily curable with penicillin, and is confined to a limited number of geographic areas, there is currently a national effort, lead by the CDC, to eliminate syphilis.² The national Healthy People goal (25-3) for the elimination of syphilis calls for the reduction of primary and secondary (P&S) syphilis to 0.2 cases per 100,000 population.³

Findings

In Nashville in 2000, there were 200 cases of syphilis reported to MPHD. Syphilis rates in Nashville increased from 1995—1999 and are now on the decrease. In 2000, the rate of P&S syphilis in Nashville was 35.1 per 100,000 population, down from 47.2 in 1999. The syphilis rate among males is higher than among females. Males in 2000, had a P&S syphilis rate 50% higher (42) than females (28). When examined by race group, a large disparity between blacks and whites is apparent. In 2000, blacks in Nashville had a P&S syphilis rate of 105.0, nearly nine times higher than the rate among whites (11.8) (Table 48). Overall, black males had a rate of 138.4 (compared to white males with a rate of 11.9) and black females had a rate of 75.9 (compared to white females with a rate of 11.7). The gender disparity widens among blacks. Among black males the rate of disease is almost twice the rate among females, however, there is virtually no gender disparity apparent among whites (Table 48).

Comparing Nashville to Tennessee and the U.S.

Nationally, the rate of primary and secondary syphilis was 2.2 per 100,000 population in 2000. If all stages of syphilis are included, the national rate was 11.6⁴. These rates are the lowest rates ever reported and are half of what they were just five years ago. In contrast, the state of Tennessee ranked first in the nation in 2000⁴ with a rate of primary and secondary syphilis of 9.4. Of those cases reported from Tennessee, 200 or 38% were reported from Nashville. Nashville also ranked first in the nation among cities >200,000 population, with the highest reported rate of primary and secondary syphilis (35.1). (Another Tennessee city, Memphis, ranked 4th with a rate of 27.4). In 2000, the rate of P&S syphilis in Nashville was nearly four times higher than the rate in Tennessee, and sixteen times higher than the national rate (Figures 156 and 157).

Gender and race disparities in syphilis rates existed in Tennessee and in the U.S. as well as in Nashville. Similar to the disparity in Nashville, U.S. men had a rate (2.7) 50% higher than women (1.8), while the gender disparity in Tennessee was less pronounced, with the rate just 15% higher among men compared to women. Blacks in Nashville had a P&S syphilis rate nearly nine times higher than whites in 2000. The disparity in Tennessee was twice as large, with blacks having a P&S syphilis rate (47.6) 24 times the rate among whites (1.7). Nationally, the disparity was even greater. Blacks in the U.S. had a P&S syphilis rate of 12.8, 32 times greater than the rate of just 0.4 among whites.

Figure 156. Primary and Secondary Syphilis Rates by Race and Gender, Nashville, TN, 1995 - 2001

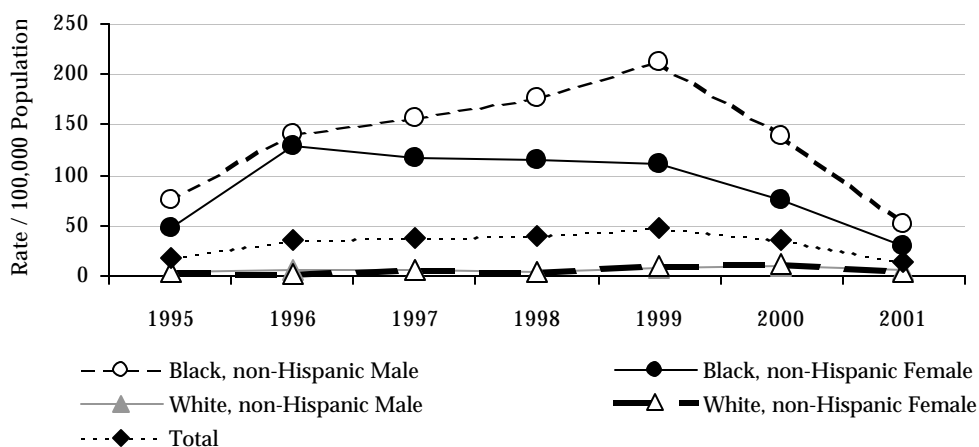
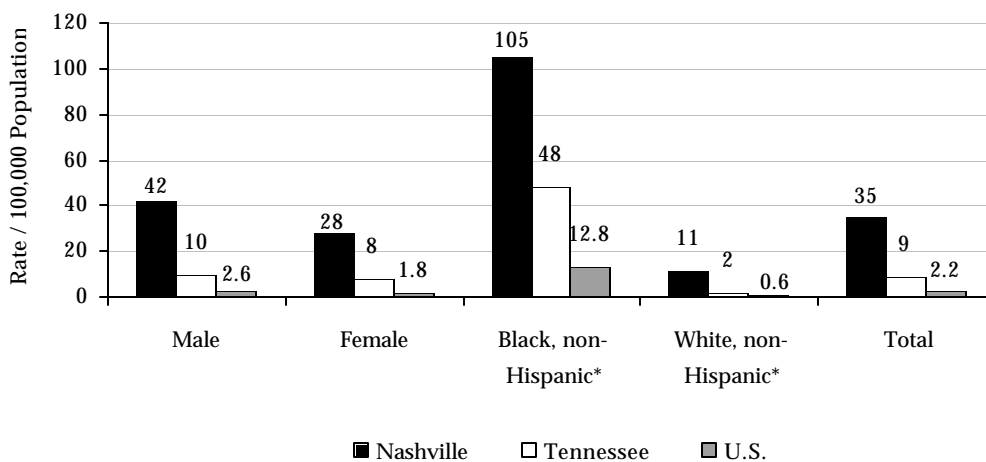


Figure 157. Primary and Secondary Syphilis Rates by Subgroup in Nashville, Tennessee, and U.S., 2000



*Ethnicity information was not available for Tennessee, therefore, rates by race for Tennessee are reported without taking ethnicity into account.

Table 48. Primary and Secondary Syphilis Rates by Subgroup, Nashville, TN, 2000

	Primary and Secondary Syphilis Rate/100,000 Population		
	Both Genders	Males	Females
TOTAL	35.1	42.4	28.2
RACE			
Black or African American	105.0	138.4	75.9
White	11.8	11.9	11.7
Ethnicity			
<i>Hispanic or Latino</i>	ψ	ψ	ψ
<i>Not Hispanic or Latino</i>	36.2	43.9	29.2
Black or African American	105.5	139.2	76.3
White	11.3	10.6	11.9
Other	ψ	ψ	ψ
AGE			
15-24	55.9	49.1	62.6
25-34	59.9	62.7	57.0
35-44	59.9	73.5	46.5
45+	19.6	37.0	5.9

ψ Less than five cases reported, rates not calculated.

Discussion

Nashville recently experienced a syphilis epidemic, which was first recognized in 1998.^{5,6} Once the epidemic was identified, MPHD took aggressive action to combat the rising syphilis rates. The rate of P&S syphilis initially increased during and shortly after the epidemic period due, in part, to increased surveillance. Since then, the rates have steadily declined as a result of the many programs that were implemented in response to the epidemic; and thanks to the efforts of health workers, doctors, nurses, and volunteers throughout Nashville.

One of the programs implemented during this time-period was the STD Free! initiative. STD Free! is a community-based coalition that works to reduce disease through the cooperation of government, professional, and community representatives. In addition to educating policy makers and the community, STD Free! targets nurses, educators, physicians, clinics, and medical students, stressing the importance of testing and reporting in both public and private practice.⁷

Another important contribution to the decline in syphilis has been the jail-based syphilis-screening program. It was recognized early on, that a large percentage of syphilis cases had previously been arrested for sex or drug related offenses.⁶ As a result, a program was implemented where all detainees at the Davidson County Criminal Justice Center (CJC) are offered voluntary syphilis screening as part of the medical intake process. If positive, individuals are treated and interviewed to identify sexual contacts and other at-risk individuals. Since the inception of this program in November of 1999, more than 30% of syphilis cases in Nashville have been identified through the CJC.

Nashville had not achieved the Healthy People 2010 goal for syphilis elimination of 2.2 new cases per 100,000 population³ by 2000. Preliminary 2001 data shows syphilis rates in Nashville falling to record lows (Figure 156). Rates have declined significantly over the past two years, and if this trend continues, Nashville should be on track to achieve syphilis elimination by 2010. Continued effort and vigilance is required to ensure that rates do not again increase.

References:

1. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 1999*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; September 2000.
2. Division of STD Prevention. *The National Plan to Eliminate Syphilis from the United States*. National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention; 1999.
3. U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition, in Two Volumes)*. Washington, DC; January 2000.
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5. Huang, J. *Epidemiology of Primary and Secondary Syphilis in Nashville and Davidson County, Tennessee (Preliminary Findings – Part One)*. Nashville, TN: Metropolitan Public Health Department of Nashville and Davidson County; October 1998.
6. Huang, J. *Primary and Secondary Syphilis in Nashville and Davidson County, TN: 1996-1999 Epidemic Risk Factors Examined (Part Two)*. Nashville, TN: Metropolitan Public Health Department of Nashville and Davidson County; July 2001.
7. MHD web-site: http://healthweb.nashville.org/cd_reporting.html. Author: Metropolitan Public Health Department of Nashville and Davidson County, Division of Communicable Disease Control. Last update/review September 7, 2000. Accessed June 12, 2002.

Nashville had not achieved the Healthy People 2010 goal for syphilis elimination of 2.2 new cases per 100,000 population by 2000. Preliminary 2001 data shows syphilis rates in Nashville falling to record lows.

3.4.3.4 HIV and AIDS

Background

In Nashville in 2000, there were 277 cases of AIDS and 248 cases of HIV reported, which corresponds to 48.6 AIDS cases and 43.5 HIV cases for every 100,000 people living in Nashville.

Acquired immunodeficiency syndrome (AIDS) was first recognized in 1981 as a new infectious disease¹⁻². AIDS is caused by the human immunodeficiency virus (HIV), which attacks the cells of the body's immune system destroying its ability to fight infection.

HIV is transmitted through contact with the bodily fluids of an infected individual such as blood, semen or vaginal fluid. It is most often transmitted by sexual contact, but can also be transmitted through an infected blood transfusion or organ transplant, through needle stick injuries or the sharing of contaminated needles, or from an infected mother to her unborn child. HIV is not transmitted through kissing or by contact with the saliva of an infected individual.

Why do we track HIV and AIDS?

HIV and AIDS have had a significant impact on the health of our nation. According to the CDC, as of December 31, 2000, 774,467 AIDS cases had been reported, and 58% of those cases are known to have died³. Tied to the emergence of HIV and AIDS, we have also seen the re-emergence of diseases once thought conquered, such as tuberculosis. In addition, the health-care costs of treatment for HIV and AIDS are extremely high. Researchers have estimated the lifetime treatment cost of a person diagnosed with HIV to be \$155,000.⁴

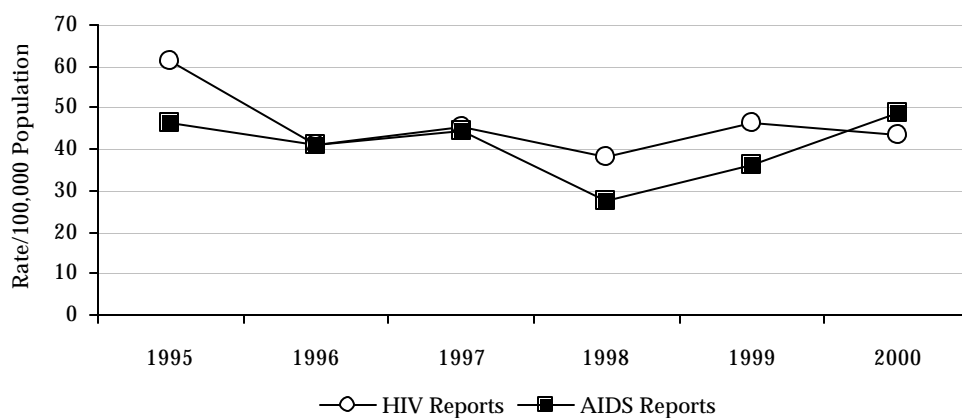
Health objectives and targets

Healthy People 2010 objective 13-1 measures the rate of new AIDS cases in the population and sets a target of 1.0 new AIDS cases among adolescents and adults (aged 13 and older) for every 100,000 persons. This measure is important because in addition to measuring newly identified infections, it is also a measure of treatment access and effectiveness among HIV positive individuals. Objectives 13-2 through 13-4 call for the reduction of AIDS cases among men who have sex with men (MSM) and injection drug users (IVDU); and objective 13-5 calls for a reduction in new HIV infections. The target for objectives 13-2 through 13-5 is a 25% improvement in the number of cases reported.¹

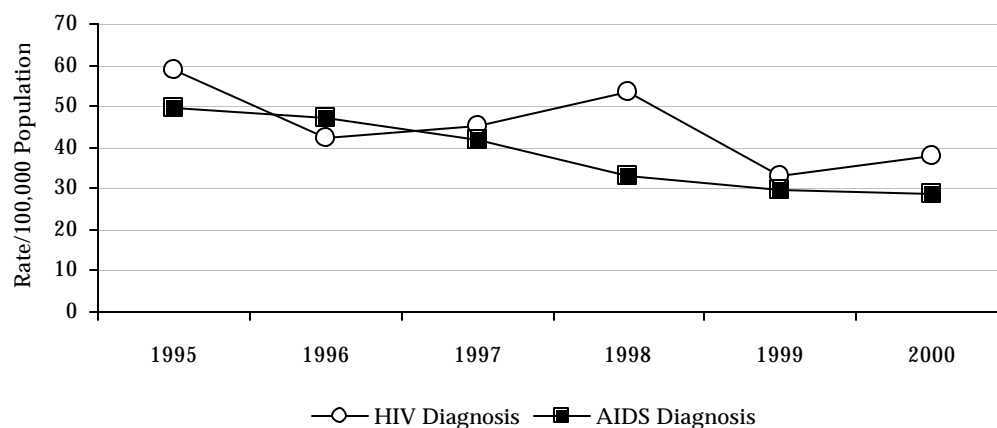
Findings

In Nashville in 2000, there were 277 cases of AIDS and 248 cases of HIV reported, which corresponds to 48.6 AIDS cases and 43.5 HIV cases for every 100,000 people living in Nashville. These rates represent an increase from previous years (Figure 158), primarily due to improved surveillance in 2000. To illustrate this point, when new cases are examined by date of diagnosis rather than date of report (Figure 159), the rate of disease decreases steadily from 1995 to 2000. The two trends are different because many of the new cases reported in 2000 had been diagnosed in previous years and were not reported until 2000. The remaining statistics in this section will be calculated based on year of report in order to be comparable to national statistics, which are also based on the date of report.

**Figure 158. Rate of HIV and AIDS by Year of Report,
Nashville, TN, 1995-2000**



**Figure 159. Rate of HIV and AIDS by Year of Diagnosis,
Nashville, TN, 1995-2000**



Of the AIDS cases reported in Nashville in 2000, 100% were adolescent/adult cases. There were no AIDS cases reported among children under the age of 13. Eighty-one percent (81%) of AIDS cases were male. The rate of disease was more than four times higher among males than among females (Figure 160). African Americans and whites each made up 49% of new AIDS cases, although the rate of disease was more than two times higher among blacks than among whites (Figure 160).

Figure 160. Rate of AIDS by Gender and Race/Ethnicity, Nashville and U.S., Reported in 2000

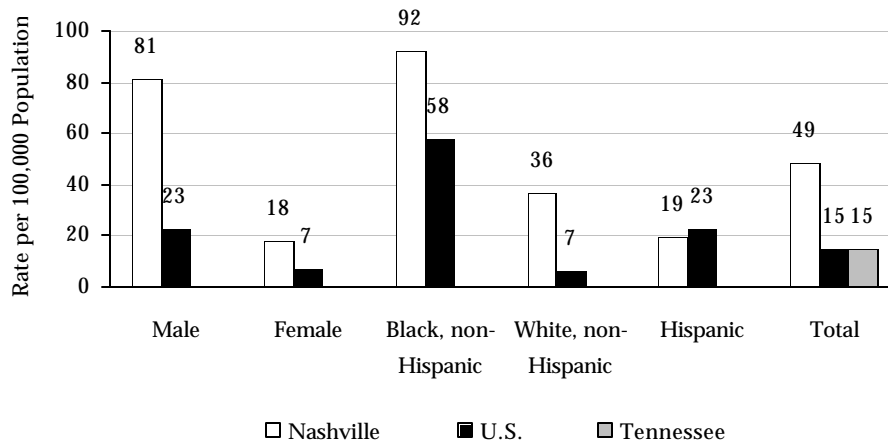
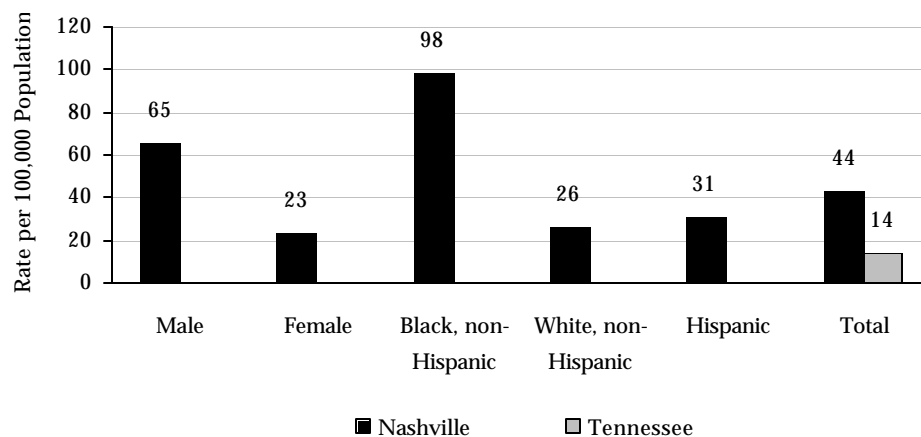


Figure 161. Rate of HIV by Gender and Race/Ethnicity, Nashville, TN, Reported in 2000



Of the HIV cases, 99% were adult cases. There were less than five new cases of HIV reported among children under the age of 13 in year 2000. Seventy-three percent (73%) of HIV cases were male. The gender disparity was not as pronounced for HIV as for AIDS, however, the rate of disease among males was still nearly three times that of females (Figure 160). Fifty-eight percent (58%) of new HIV cases were black, 39% were white, and 3% were Hispanic. Similar to the racial disparity seen among AIDS cases in Nashville, rates of HIV among blacks were nearly four times higher than rates among whites and Hispanics (Figure 161).

MSM made up the largest mode of exposure group, with 53% of AIDS cases and 48% of HIV cases. Twenty-three (23%) of AIDS cases, and 19% of HIV cases were reported among IVDUs; and 12% of AIDS cases and 21% of HIV cases were attributed to heterosexual contact.

Comparing Nashville to other metropolitan areas, Tennessee, and the U.S.

It is expected that rates of disease in Nashville will be higher than the disease rates for the state or for the U.S. as a whole because Nashville is an urban center. However, when we compare the rate of AIDS in Nashville to a composite rate (20.4 per 100,000 population) from all metropolitan areas with 500,000 or more population, the rate of disease in Nashville is still twice as high as the composite rate for this group. Published CDC statistics rank Nashville 14th by rate and 21st by sheer numbers, among 103 cities with populations greater than 500,000³.

As expected, when we compare the rates of disease in Nashville to Tennessee rates and U.S. rates, the AIDS rate in Nashville is three times higher than both the Tennessee rate and the national rate. Compared to the U.S. rate, the rate of AIDS in Nashville is four times higher among males, 2.5 times higher among females, 5.5 times higher among whites, almost twice as high among blacks, while the rate of disease among Hispanics is slightly lower than the national rate. The HIV rate in Nashville is also three times higher than the rate in Tennessee overall. National HIV rates were not calculated. (See Technical Notes.)

Similar to the situation in Nashville, HIV and AIDS also disproportionately affect men who have sex with men (MSM) across the U.S., making up 32% of AIDS cases and 29% of HIV cases reported³, however the *proportion* of MSM cases in Nashville is much higher than in the U.S. overall. HIV and AIDS transmission among MSM are typically facilitated by “high-risk sexual practices” in “highly infected sexual networks”¹ with high rates of disease as a result. The disproportionate amount of new AIDS and HIV cases among MSM in Nashville compared to the U.S., coupled with the high rate of disease among males in Nashville, suggests continuing high-risk behaviors and increasing transmission in the MSM community. These findings highlight the need for aggressive prevention and education strategies in the MSM community to decrease HIV transmission.

Nationally, 20% of new AIDS cases reported in 2000 were exposed through IV drug use, similar to the proportion of cases in Nashville attributed to IV drug use. However, only 10% of new HIV cases reported nationally were attributed to IV drug use in 2000 in comparison to 19% in Nashville indicating that the combination of IV drug use and transmission of HIV, while declining nationally, is a continued concern in Nashville.

The proportion of black AIDS cases in Nashville and the U.S. are similar, however, whites make up a much larger percentage of new AIDS cases, and Hispanics make up a much smaller percentage of new AIDS cases, in Nashville compared to the U.S. (Figure 160).

Of the HIV cases, 99% were adult cases. There were less than five new cases of HIV reported among children under the age of 13 in year 2000.

Discussion

There have been many successes in the prevention of HIV and AIDS in Nashville and across the country. With the introduction of new drugs and highly active anti-retroviral therapies (HAART), infected individuals are living with HIV far longer than ever before. In addition, the use of AZT and other drugs in HIV infected pregnant women has cut mother to child transmission drastically in recent years.

Rates of disease in Nashville far exceed the Healthy People 2010 objectives and will most likely continue to exceed these levels because Nashville is an urban center. The rate of decline in AIDS cases appears to be leveling in Nashville, and HIV cases appear to be increasing slightly. However, much improvement and reduction in the transmission of HIV is possible if prevention efforts are targeted at those population subgroups with increasing rates (blacks and women), and those communities with the highest transmission rates (MSM and IV drug users).

References:

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2. Benenson, AS, ed. *Control of Communicable Diseases Manual*. 16th ed. Washington, DC: American Public Health Association; 1995.
3. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 2000; 12 (No.2).
4. Centers for Disease Control and Prevention. *HIV Prevention Strategic Plan through 2005. Appendix C*. January 2001.

Rates of HIV and AIDS in Nashville far exceed the Healthy People 2010 objectives and will most likely continue to exceed these levels. The rate of decline in AIDS cases appears to be leveling in Nashville, and HIV cases appear to be increasing slightly.

Related Indicators

- Cancer screening
- Leading causes of death
- Years of potential life lost
- Sexually transmitted diseases
- Economic dimension of health problems

3.5 Cancer Incidence

Background

Cancer is a diverse group of diseases characterized by uncontrolled growth and the spread of abnormal cells ¹. If the spread is not controlled, it can result in death. Cancer is caused by external and internal factors. Anyone can get cancer. The lifetime probability of developing cancer is higher in men (1 in 2) than in women (1 in 3) ². Cancer incidence is one of the most important indicators in assessing the population-based risk of developing cancer. Each year, newly diagnosed cancer cases are reported to the Tennessee Cancer Registry, which was established in 1984. Since new cases diagnosed and treated in non-hospital facilities were not reported before 2000, incidence data between 1980s and 1990s may not be 100% accurate. Due to reporting and data processing delay, a few years of time lag is expected regarding incidence data availability. However, cancer incidence is still the best indicator to monitor a community's cancer occurrence trend.

Cancers are usually classified according to their organ or tissue of origin (site code) and according to their histologic features (morphology code). ¹ In this report, we report cancers by site.

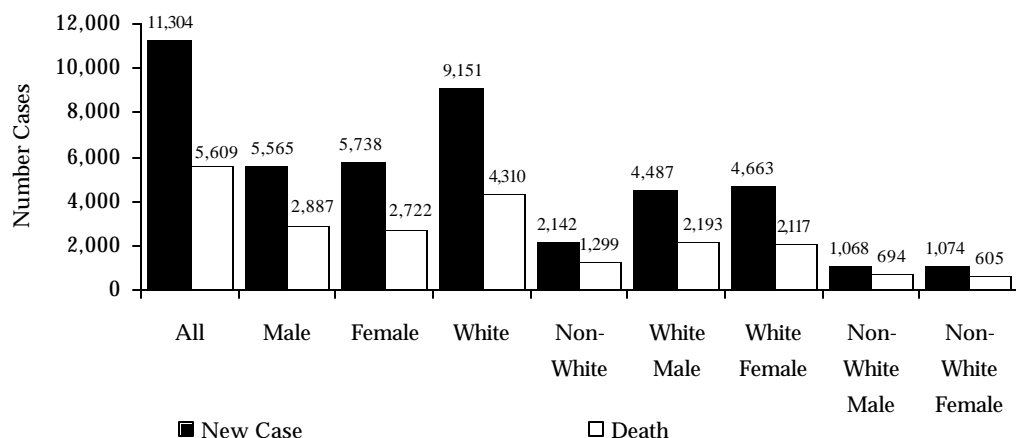
Additional Data

Appendices
pages D-82 - D-83

Findings

From 1992 to 1996, 11,304 new cancer cases were reported in Nashville. Of these new cases, 5,565 (49.2%) were diagnosed in males and 5,738 (50.8%) were diagnosed in females, 9,151 (81.0%) cases were white, and 2,142 (18.9%) cases were non-white. (Information regarding subcategories of non-white was not available). During the same time period, there were 5,609 cancer deaths, approximately half (49.6%) of newly diagnosed cancer cases (Figure 162).

Figure 162. Number of New Cancer Cases and Number of Cancer Deaths by Gender and Race, Nashville, TN, 1992-1996



Data Sources

Tennessee Department
of Health

Of all cancer sites, the top three sites were lung, female breast, and colon. Together, these three sites had almost half (47.3%) of all newly diagnosed cancer cases. For males, the top three cancer sites were prostate, lung, and colon, accounting for more than half (56.8%) of new cancer cases in males. For females, the top three cancer sites were female breast, lung, and colon, accounting for more than half (55.3%) of new cancer cases in females. For whites, the top three cancer sites were lung, female breast, and prostate, accounting for nearly half (47.3%) of new cancer cases in whites. For non-whites, the top three cancer sites were lung, female breast, and prostate, accounting for nearly half (47.3%) of new cancer cases in non-whites (Figures 163 - 167).

Figure 163. Ten Leading Cancer Sites, Nashville, TN, 1992-1996

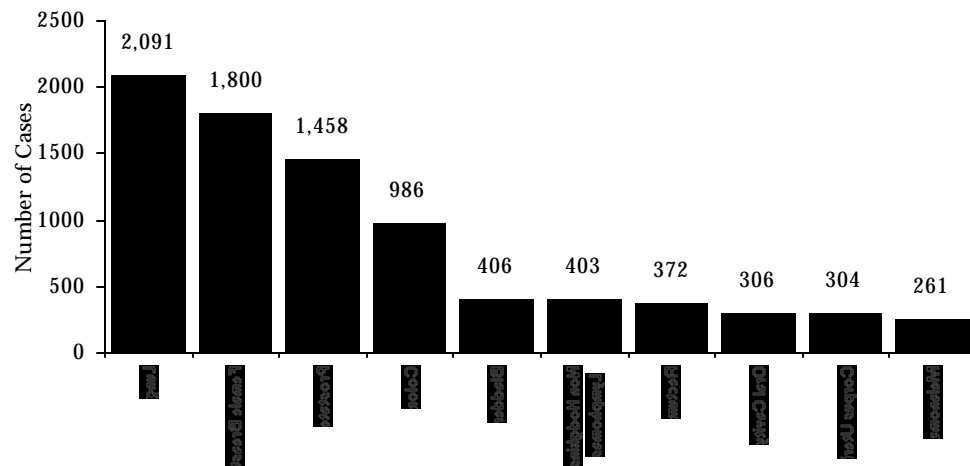
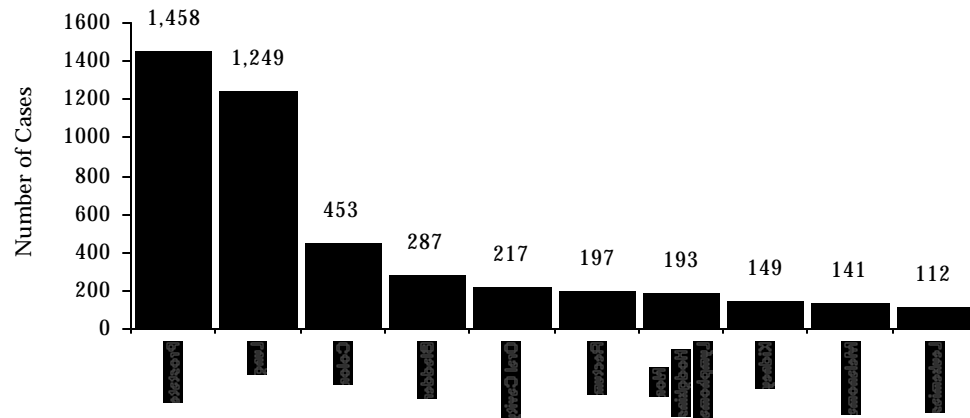
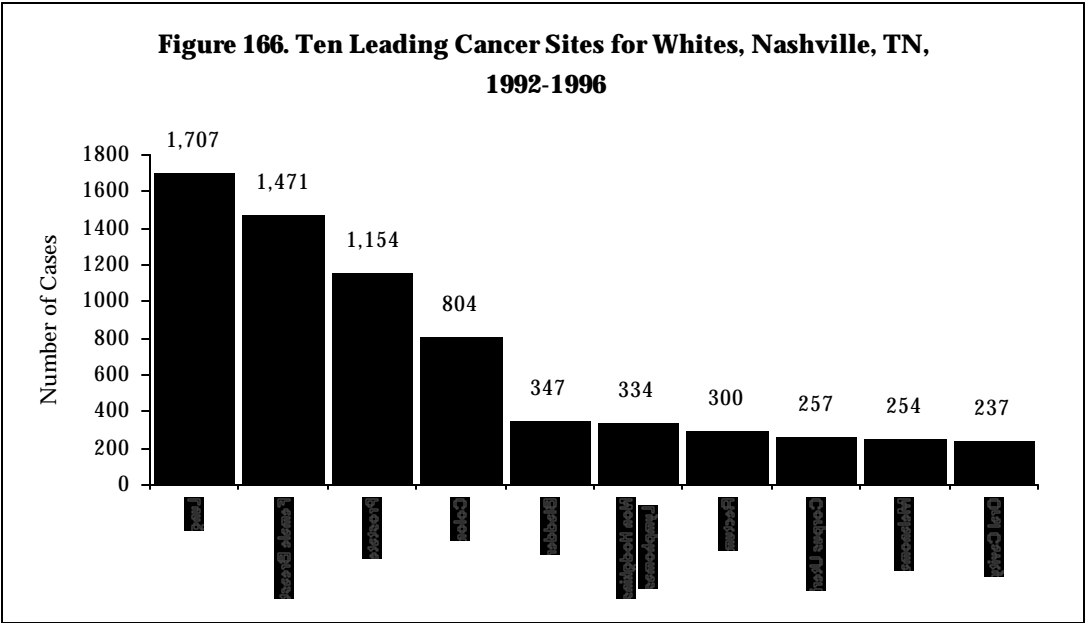
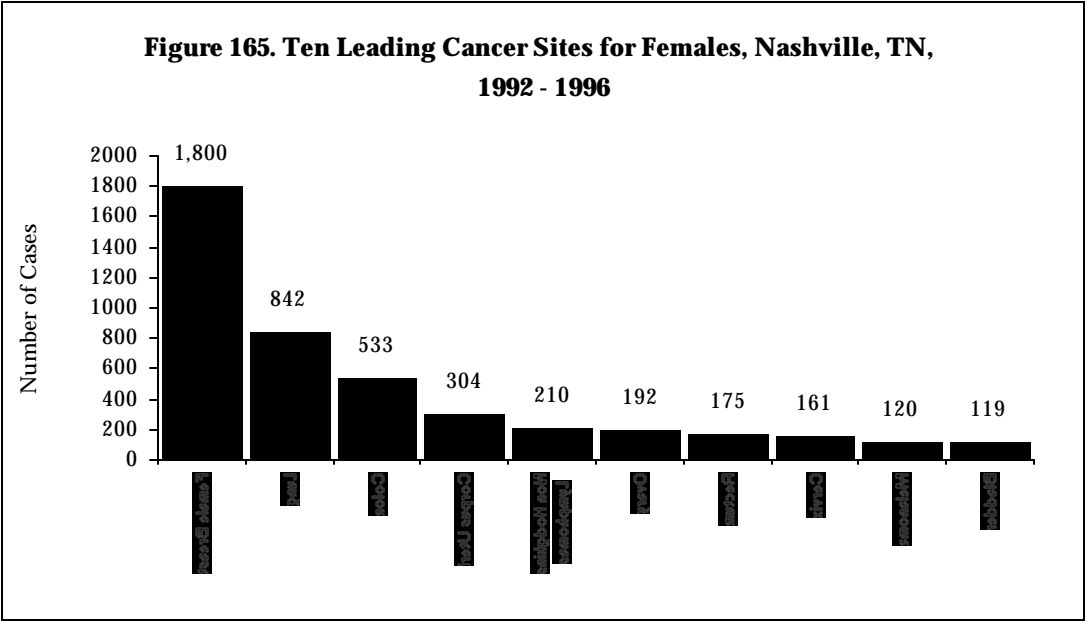


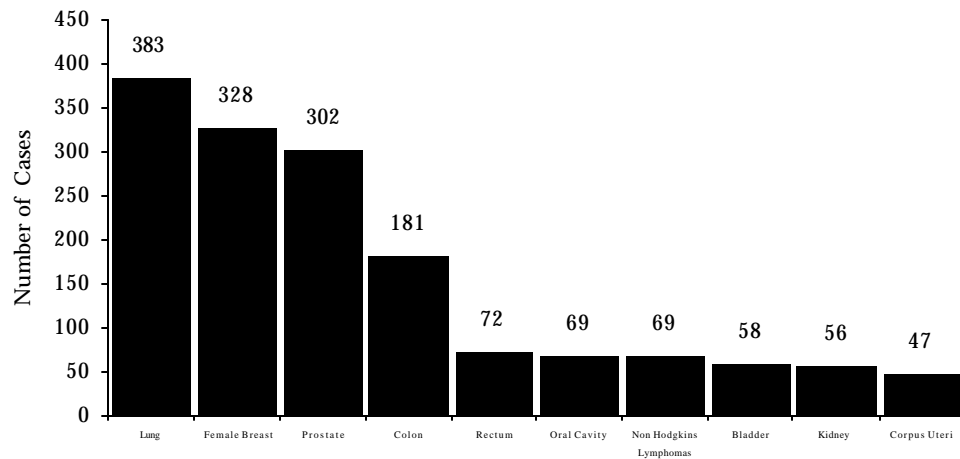
Figure 164. Ten Leading Cancer Sites for Males, Nashville, TN, 1992 - 1996





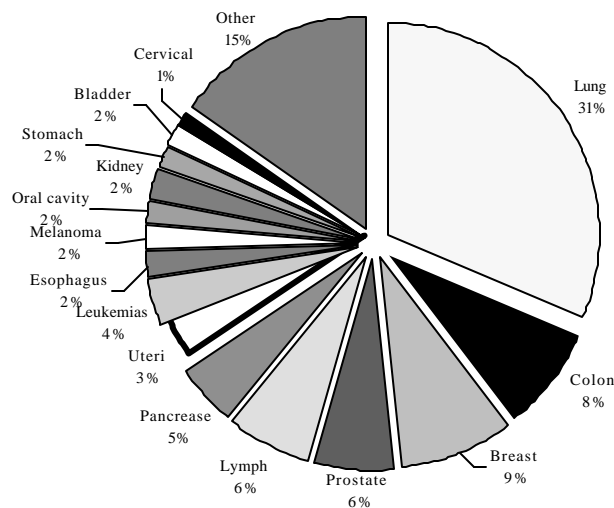
Of all cancer sites, the top three sites were lung, female breast, and colon.

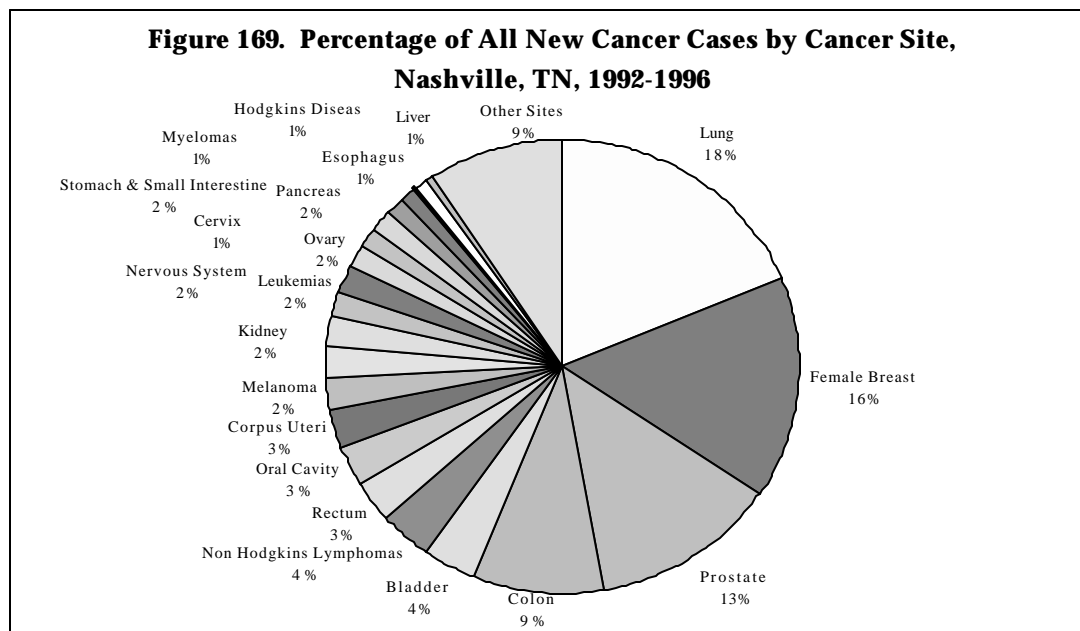
Figure 167. Ten Leading Cancer Sites for Non-Whites, Nashville, TN, 1992-1996



Figures 168 and 169 reveal that although lung cancer accounted for 18% of all new cancer cases during 1992-1996, it was responsible for 31% of all cancer deaths during the same period. In contrast, female breast cancer accounted for 16% of new cases, but was only responsible for 9% of cancer deaths. While prostate cancer accounted for 13% of new cases, it was only responsible for 6% of cancer deaths. Likewise, 9% of new cancer cases were due to colon cancer but 8% of all cancer deaths during this time period were from colon cancer.

Figure 168. Percentage of All Cancer Deaths by Cancer Site, Nashville, TN, 1992-1996





Examination of the overall cancer incidence trend in Nashville from 1992 to 1996 revealed that the age-adjusted cancer incidence declined from 1992 to 1994, and increased slightly between 1994 to 1996. This trend was observed for the total population and for both males and females. For whites, the declining trend ended in 1995 and began to increase in 1996. For non-whites, the trend was declining until 1994, but had a dramatic increase in 1995, and then declined again in 1996 (Figures 170-172).

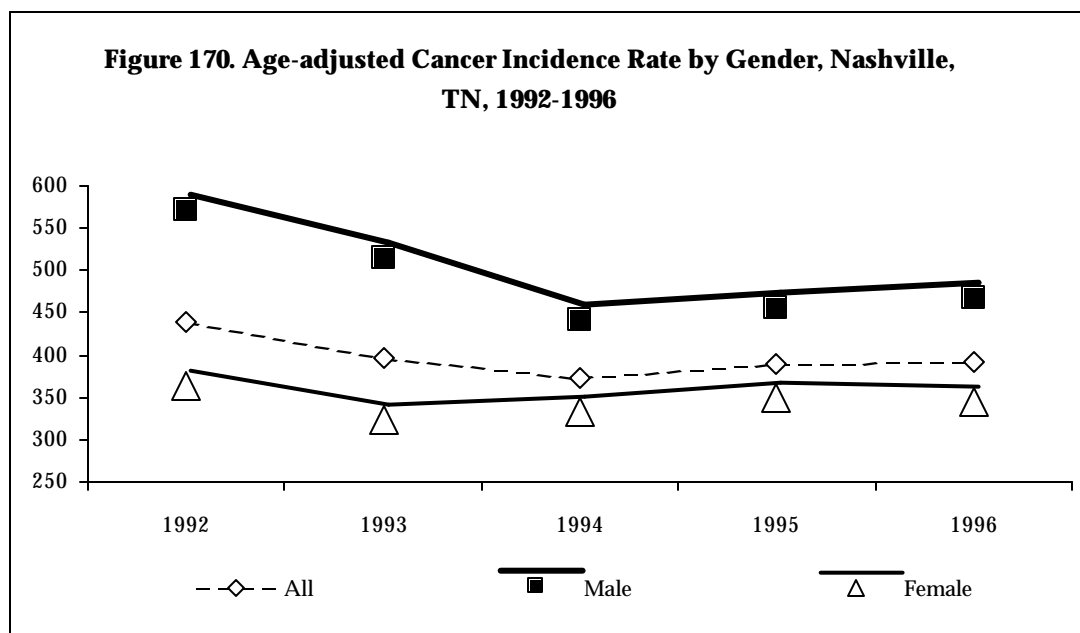


Figure 171. Age-adjusted Cancer Incidence Rate by Race, Nashville, TN, 1992-1996

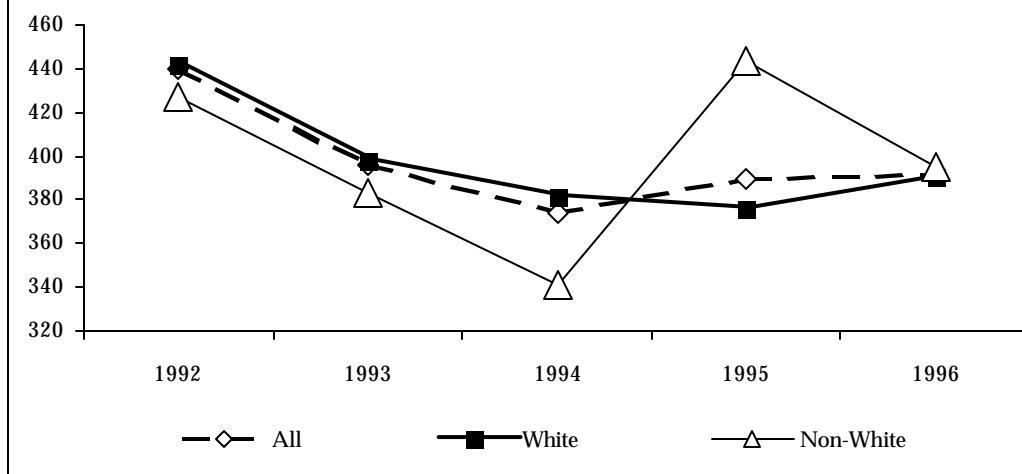
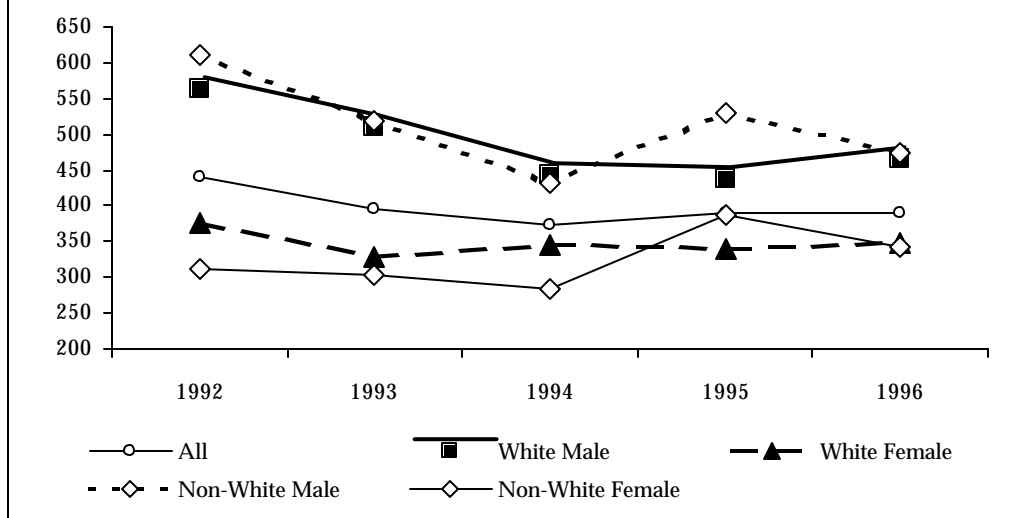
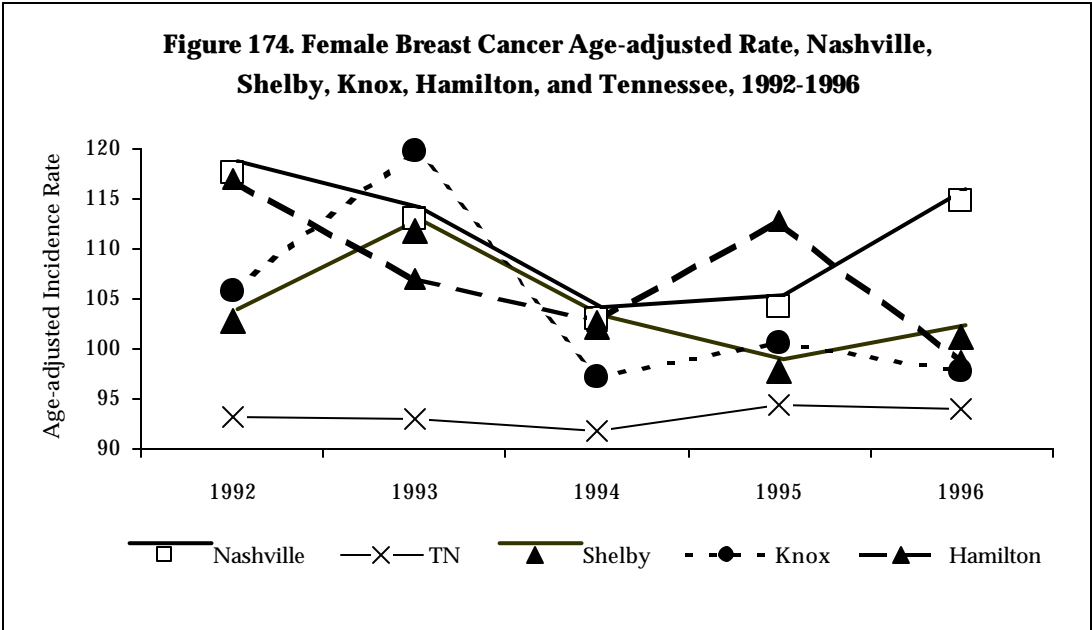
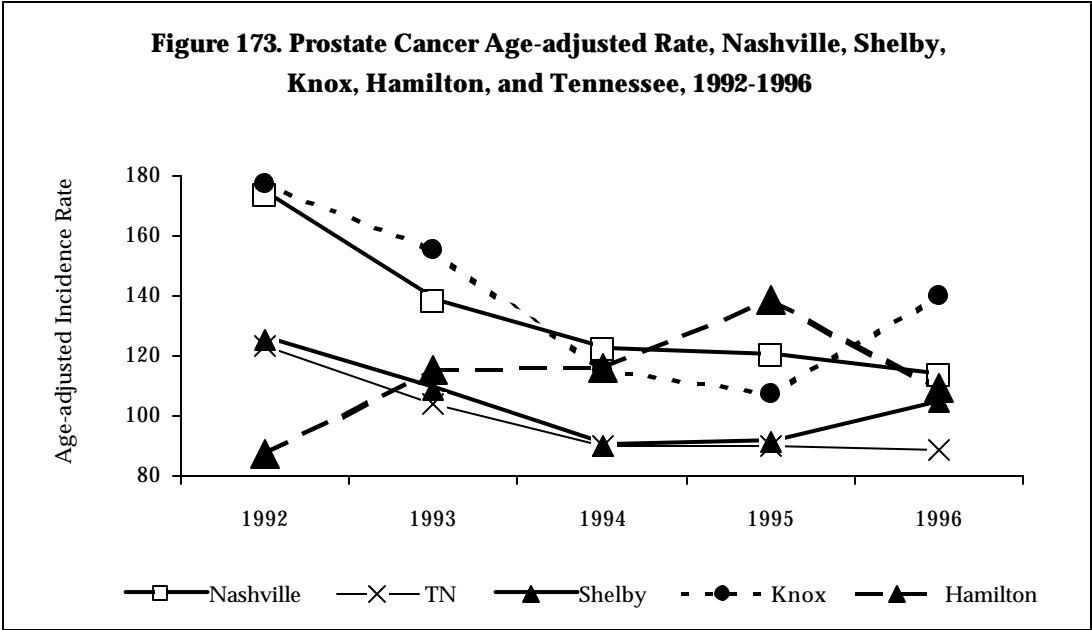


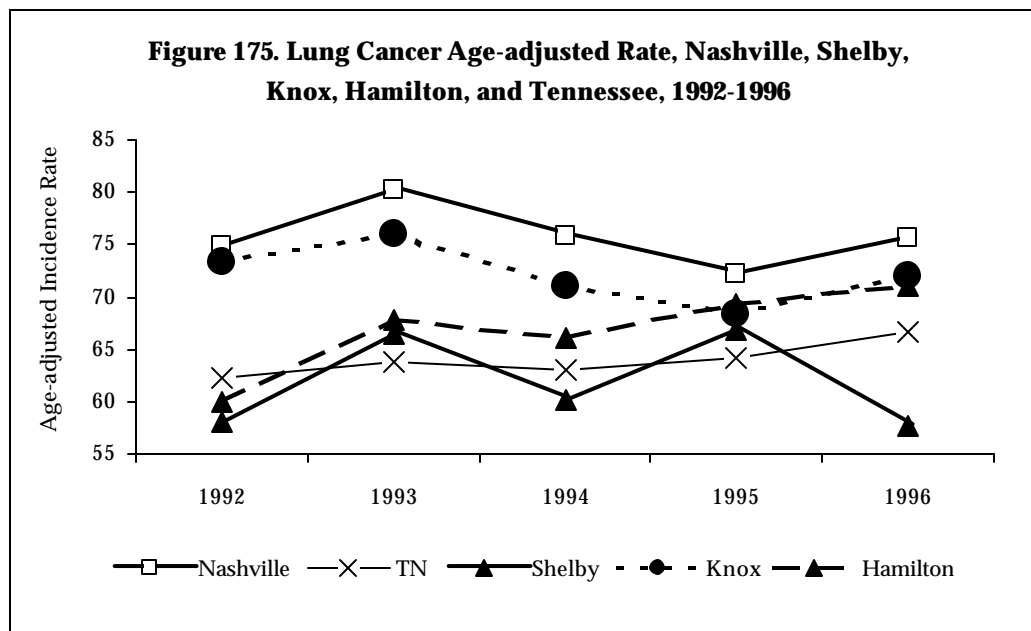
Figure 172. Age-adjusted Cancer Incidence Rate by Gender and Race, Nashville, TN, 1992-1996



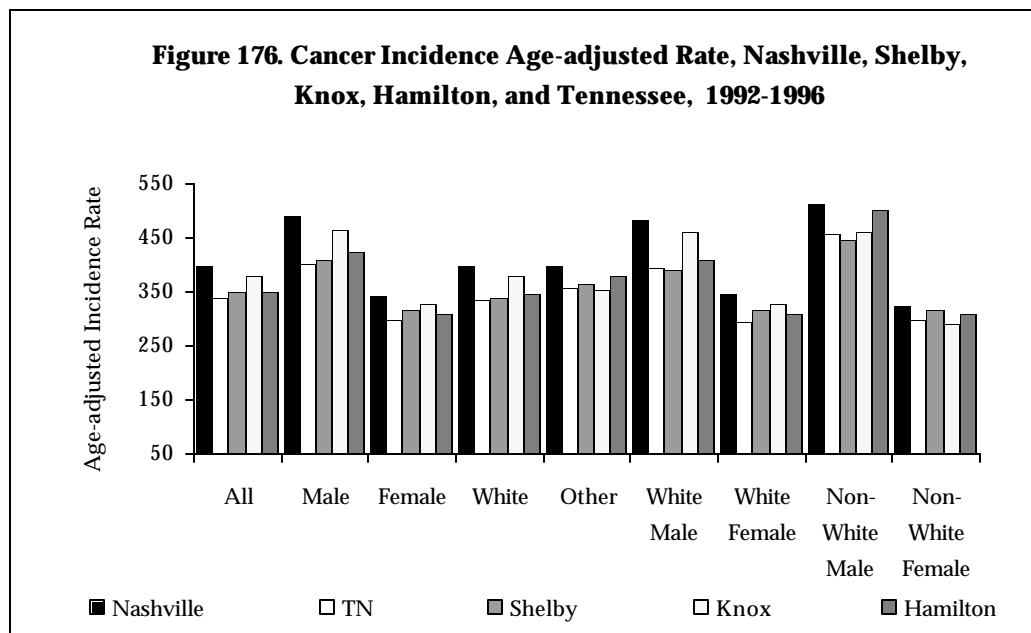
A further examination of cancer incidence trends by site revealed that while prostate cancer demonstrated a continuous decline from 1992-1996, female breast cancer exhibited a declining trend from 1992-1994 but increased from 1995 to 1996. Lung cancer fluctuated slightly but remained relatively stable (Figures 173-175).



Although lung cancer accounted for 18% of all new cancer cases during 1992 - 1996, it was responsible for 31% of all cancer death during the same period.



When comparing Nashville's cancer incidence rates with that of Tennessee and three other metropolitan counties (Shelby, Knox, Hamilton), Nashville's rates were consistently higher. This holds true across gender and race (Figure 176).



Nashville also had consistently higher rates than Tennessee, Shelby, Knox, and Hamilton Counties for lung cancer (Figure 175). Similarly, Nashville's female breast cancer rates were higher than the comparison groups for the years 1992, 1994, and 1996 (Figure 174). For prostate cancer, Nashville's rates were consistently higher than those of Tennessee and Shelby County. The prostate cancer rate was higher than that of all three metropolitan counties only in 1994 (Figure 173). For colon cancer, Nashville's rate is higher than that of Tennessee, and Shelby, Knox, and Hamilton Counties for all years except 1994 (Figure 177). For bladder cancer, Nashville's rate increased from the lowest among Tennessee and four metropolitan counties in 1992 to the highest in 1993, 1994, and 1995. The rate then declined again in 1996 to the second lowest among Tennessee and four metropolitan counties (Figure 178).

Figure 177. Colon Cancer Age-adjusted Rate, Nashville, Shelby, Knox, Hamilton, and Tennessee, 1992-1996

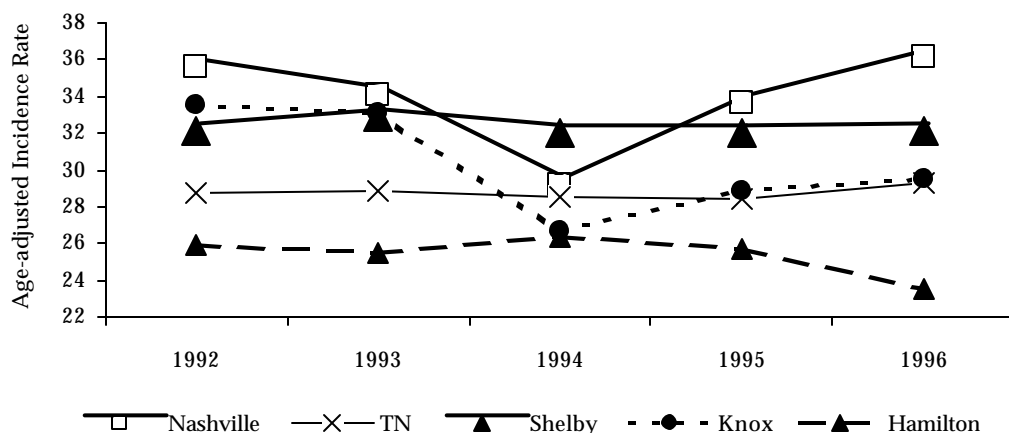
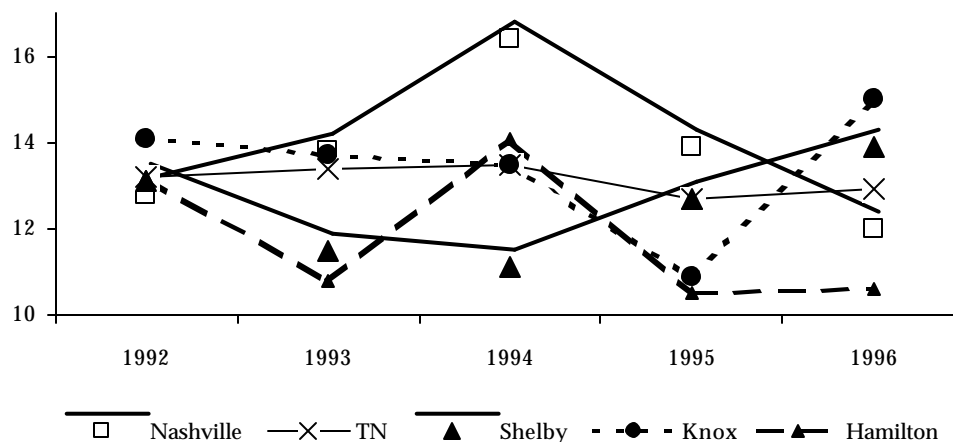


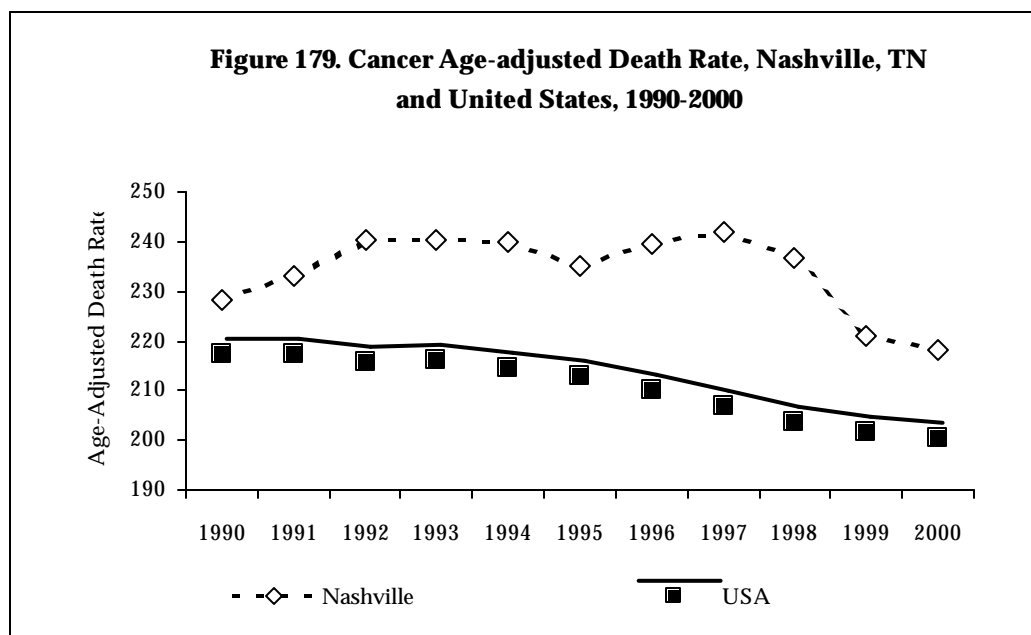
Figure 178. Bladder Cancer Age-adjusted Rate, Nashville, Shelby, Knox, Hamilton, and Tennessee, 1992-1996



Discussion

Healthy People 2010's goal regarding new cancer cases is to "reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer," but there were no specific objectives for new cancer cases.³ According to *Cancer Progress Report 2001* released by the National Cancer Institute, our nation's efforts in cancer prevention and control are making a difference. Across the nation, people are adopting good health habits that reduce cancer risk. The rates of new cancers are decreasing, and cancer death rates overall have dropped. Additionally, improvements in treatment options are helping people who have had cancer live longer, with the opportunity to enjoy a better quality of life than was possible years ago. Despite these improvements, however, cancer remains a major public health problem - one that profoundly affects the more than 1 million people diagnosed each year, as well as their families and friends.⁴

Overall, the assessment of our nation's cancer situation is applicable on a local level. Nashville's cancer mortality data show a declining trend during 1990 to 2000 (Figure 179). However, Nashville's decline is not as smooth as the nation's cancer decline. Mortality rates increased from 1990 to 1992, plateaued from 1992 to 1994, decreased from 1994 to 1995, increased again from 1995 to 1997, and then began to decrease from 1997 to 2000. Regarding cancer incidence, the age-adjusted incidence rate decreased from 1992 to 1994 and increased slightly from 1994 to 1996. Since the latest cancer incidence data is not available at this time, it is difficult to predict the future of this trend. However, 1992-1996 cancer incidence data suggest that cancer is still a major public health problem in our community. On average, 2,261 Nashville residents were newly diagnosed with cancer, and 1,122 Nashville residents died of cancer each year during 1992-1996. The impact on the patients, their families and friends, and community as a whole is enormous.



References:

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3. U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition, in Two Volumes)*. Washington, DC: January, 2000.
4. National Cancer Institute. *Cancer Progress Report 2001* [online]. Available at: <http://progressreport.cancer.gov/index.asp>. Accessed February 20,2002.

Nashville's cancer mortality data show a declining trend during 1990 to 2000. Regarding cancer incidence, the age-adjusted incidence rate decreased from 1992 to 1994 and increased from 1994 to 1996.

Chapter Four

Consequences of Health Problems

Health consequence consists of quality of life, use of health services, use of medication, short-term and long term disability, and others.¹

Quality of life is partially addressed in section 3.1 of this report. We are not able to analyze health service and medication utilization data because they are currently not available to us. The same is true for disability data. We are currently addressing the issue of lack of data sources and expect that at least part of these data will be presented in the next edition of his report.

Reference:

1. Bernier L, Sauvageau Y, et al. *User's Guide to 40 Community Health Indicators*. Health and Welfare Canada; 1992.

Related Indicators

- Leading causes of death
- Years of potential life lost
- Ten most frequently reported notifiable diseases/conditions
- Sexually transmitted diseases
- Cancer incidence

4.1 Economic Dimension of Health Problems

Background

The economic dimension of health consequences has become a common topic in public health recently.¹⁻⁸ Translating health consequences into currency allows us to make comparisons among different health outcomes. It also allows us to document the economic burden of disease, injury, and disability in the community and to demonstrate the costs, benefits, effectiveness, and utility of public health interventions. In this section, we apply economic analysis results from literature to selected local data to approximate the economic burden of health problems in our community. Please note that economic analysis of health consequences is not without limitations. For example, mortality cost estimation requires very restrictive assumptions about employment patterns, replacement cost, and labor market trends.³

Findings

Numerous studies translate disease burdens into an actual currency. Estimated costs for selected conditions in the United States are summarized in Table 49.

Table 49. Estimated Cost of Health Conditions in U.S.¹⁻⁸

Condition	1st year Cost of Treatment/patient	Overall Cost
Coronary heart disease	\$30,000	\$6.99 billion/year
Cancer		Breast: \$2.32 billion/year
		Endometrial: \$0.79 billion/year
		Colon: \$2.79 billion/year
	Lung: \$29,000	
	Cervical: \$28,000	
		All: \$104 billion
Stroke	Hip fracture: \$40,000	
	Quadriplegia: \$570,000 (lifetime)	
		All: \$30 billion
HIV	\$20,000 per year	\$7-8 billion/year
Low birth weight	\$10,000	
Congenital rubella syndrome	\$354,000 (lifetime)	
Smoking	\$3,391 per year	\$157.7 billion/year
Type II diabetes		\$63.14 billion/year
Osteoarthritis		\$18.31 billion/year
Obesity		\$99.2 billion/year
Food-borne diseases		\$2.9-6.7 billion/year
Diabetes		\$93 billion
Depression		\$44 billion
Injury	Mortality cost: \$307,636 per death	
	\$2,772 per injured person	\$157.6 billion (1995)

During a 10 - year period from 1991 - 2000, 2,147 persons in Nashville died of injury. This represents a \$1.09 billion cost to Nashville.

Applying these estimates to local data, we may be able to gain a perspective of economic dimension of health consequences in our community. In the following examples, injury death and HIV/AIDS data are used to demonstrate economic cost of disease burden in Nashville.

According to a 1985 cost of injury study, injury cost is \$2,772 per injured person in 1985 dollars,³ or \$ 4,573 in 2002 dollars; mortality cost is \$ 307,636 per injury death, or \$507,485 in 2002 dollars. During a 10-year period from 1991-2000, 2,147 persons in Nashville died of injury. This represents a \$1.09 billion cost to Nashville.

According to a 2000 study of cost of treating persons with HIV disease, average annual cost were between \$20,000 to \$24,700 per person.⁷ In Nashville, there were 277 cases of AIDS and 248 cases of HIV reported in 2000. Cost of treating AIDS per year is estimated at between \$5.5 million and \$6.8 million. If eventually we have to treat HIV cases as well, the cost will jump to between \$10.5 and \$13 million.

Discussion

Consequences of health problems are closely related to health status. Health consequences affect both the individuals and society. Using HIV/AIDS as an example, most people with HIV/AIDS depend on public sources to pay for their needed health care services.⁷ As a result, this suggests that even though the majority of citizens in Nashville do not have HIV/AIDS, the economic burden of caring for HIV/AIDS patients is on the entire community. Therefore, it is important for every citizen to work collectively to address the consequences of health problems in our community.

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Appendices

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ICD Codes.....*page 259*

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Glossary

Acute health condition, according to the National Center for Health Statistics, is a departure from a state of physical or mental well-being that has lasted for less than 3 months and has involved either a physician visit or restricted activity. In general terms, acute health condition refers to a health effect that is brief, intense, or short-term.

Age-adjusted rate is a summary rate which has been mathematically standardized to some reference population to allow for comparisons between different populations that do not have the same age-distribution. To calculate age-adjusted rates, rates are calculated by age-groups then these age-specific rates are multiplied by a number (or fraction) that represents the proportion of that age-group in the standard population. The modified age-specific rates are then summed over all the age-groups to produce the summary age-adjusted rate.

Age-adjusted mortality rate is the mathematically standardized death rate. Death rates in this report were standardized to the U.S. 2000 standard million population. For more information see the definition for age-adjusted rate.

AIDS is Acquired ImmunoDeficiency Syndrome, a condition caused by HIV in which a person's defenses against infections are decreased.

Air pollution, as defined by the Metro Code of Laws, refers to the presence in the outdoor atmosphere of one or more air pollutants in such quantities, characteristics or duration as is or tends to be injurious to human health or welfare, or animal or plant life or health, or property, or would interfere with the enjoyment of life or property.

Ambient air refers to outside air.

Aquifer The American Heritage Dictionary defines an aquifer as an underground bed or layer of earth, gravel, or porous stone that yields water.

Arboviruses are a group of viruses that are maintained in nature and transmitted to humans primarily by blood-feeding arthropods such as mosquitoes (**Arthropod-borne virus**). Infection in humans occurs when the infected arthropod bites and takes a blood meal.

Assessment is the process whereby public health agencies identify health problems and health resources, evaluate their effectiveness, and present the results of these analyses to decision-makers and the public.

Average daily hospital census is the mean number of beds which are filled in a hospital on a daily basis, during a specified period of time, usually one year.

Bioterrorism is the intentional or threatened use of viruses, bacteria, fungi, or toxins from living organisms to produce fear, death, or disease in humans, animals, or plants.

Birth Rate: A summary measure of births based on the number of live births in a population during a specified time period.

Birth Rate = $\frac{\text{Number of live births in an area in a calendar year}}{\text{Average or midyear population in that area in that year}} \times 1,000$

Cancer is a family of over 100 different diseases fundamentally characterized by uncontrolled cell growth in the body.

Census tract is a U.S. Census Bureau defined area, a small, relatively permanent statistical subdivision of a county...designed to be relatively homogenous with respect to population characteristics, economic status, and living conditions. It contains a population of approximately 4,000 individuals (range 1,000 – 8,000). Its subdivision, the block group, is the smallest geographic census unit for which census socioeconomic data are tabulated. (Census block average population = 1,000).

Chronic health condition, according to the National Center for Health Statistics, is a departure from a state of physical or mental well-being that has lasted for 3 months or more or is a condition classified as chronic regardless of its time of onset (for example, diabetes, heart conditions, emphysema, and arthritis). In general terms, chronic health condition refers to a health effect that lasts a long time.

Community The Merriam-Webster Dictionary defines community as “a unified body of individuals; the people with common interests living in a particular area; an interacting population of various kinds of individuals (as species) in a common location, a group of people with a common characteristic or interest living together within a larger society.”

Comorbidity refers to the state in which a person has more than one disease or disability-causing condition.

Congenital Anomalies are abnormalities presented at birth.

Consequences of health include disability (long-term and short-term), the use of health services, the use of medication and quality of life.

Council or Councilmanic District Thirty-five (35) councilmanic districts were created by the Charter of the Metropolitan Government of Nashville and Davidson County, Tennessee. According to article 3 of the Charter, “There shall be thirty-five (35) councilmanic districts in the metropolitan government, which are hereby created and established in accordance with the detailed descriptions thereof by metes and bounds as set forth in Appendix Two hereto attached as a part of this Charter.” “The descriptions of the councilmanic districts given in this appendix were originally promulgated in Bill No. 81-701, § adopted Oct. 6, 1981. Descriptions of Districts 1 — 35 were entirely amended in the redistricting plan adopted by referendum vote on Sept. 5, 1991.”

Crude Death Rate is the proportion of the population that has died in a specific period of time (usually one year). It is calculated with the following formula

$$\frac{\text{Number of deaths during a specific period}}{\text{Number of persons at risk of dying during the period}} \times 100,000$$

The rate is considered an estimate because the denominator commonly used is an estimate of the mid-year population.

Diabetes is a chronic, metabolic disease characterized by high blood glucose levels caused by a deficiency of insulin production, an impairment of insulin action, or both.

Digital Rectal Exam is an examination of the lower rectum in which the clinician uses a lubricated, gloved finger to evaluate the prostate gland in men and check for other abnormalities or blood in both men and women.

Ecosystem is an ecological community together with its environment, functioning as a unit.

Endemic refers to the constant presence of a disease or infectious agent within a given geographic area. It may also refer to the usual prevalence of a given disease within such area.

Environment includes all those matters related to health which are external to the human body and over which the individual has little or no control. In this document, we refer to environment as (1) physical environment, including all areas of environmental health, and (2) social environment, including, demographic indicators, sociodemographic indicators, and socioeconomic indicators.

Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control of health problems. "Study" includes surveillance, observation, hypothesis testing, analytic research, and experiments.

Estimate is to determine roughly the size, extent, or nature of something, a rough or approximate calculation.

Fecal Occult Blood Test a non-invasive colon cancer screening test in which the stool is examined for hidden blood.

Fertility is defined, according to the Dictionary of Epidemiology, as the production of live offspring. Since fertility is restricted to live births, fetal deaths and stillbirths are not included.

Fertility rate is a measure of fertility in a population. It is a more refined measure than the birth rate. It is calculated as follows:

$$\frac{\text{Number of live births in an area during a year}}{\text{Midyear female population age 15-44 in same area in same year}} \times 1,000$$

Fetal Death, or stillbirth, is defined by the World Health Organization (WHO) as "death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles." The state of Tennessee requires all fetal deaths 500 grams or greater to be recorded. If birth weight is unknown, then the fetal death must be at least 22 weeks of gestation.

Fetal Death Rate is a measure of fetal deaths within a population. It is calculated as follows:

$$\frac{\text{Number of fetal deaths in a year}}{\text{Number of fetal deaths plus live births in the same year}} \times 1,000$$

GIS (Geographic information system) is an organized collection of computer hardware, software, geographic data, and personnel designed to efficiently capture, store, update, manipulate, analyze, and display all forms of geographically referenced information.

Groundwater The American Heritage Dictionary defines groundwater as water beneath the earth's surface, often between saturated soil and rock, that supplies wells and springs.

Health is a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity.

Health care system consists of the quantity, quality, arrangement, nature, and relationship of people and resources in the provision of health care.

Health status is related to a more medical view of health. It is generally accepted that there are two components to health status, (1) a subjective one based on an individual, personal reading of health status, and (2) a so-called objective one based on a normative, professional assessment. Subjective health status is defined as a person's own assessment of his or her health. Objective health status refers to an assessment by a health professional. It is recognized that a professional assessment remains a judgement, though based on criteria that are more specific and on which some consensus has been reached. Objective health includes mortality, morbidity (hospital morbidity, non-hospital morbidity, physician visit and non-physician visit).

Heart Disease refers to a group of heart diseases, including coronary or ischemic heart disease, hypertensive heart disease, and rheumatic heart disease.

Hepatitis C as defined by the CDC in "Case Definitions for Infectious Conditions Under Public Health Surveillance" is an acute illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase levels. The laboratory criteria that are necessary for diagnosis are:

1. Serum aminotransferase levels greater than 2.5 times the upper limit of normal, and
2. IgM anti-HAV negative, and
3. IgM anti-HBc negative (if done) or HbsAg negative, and
4. Antibody to hepatitis C virus (anti-HCV) positive, verified by a supplemental test.

HIV is Human Immunodeficiency Virus, the virus causes acquired immunodeficiency syndrome (AIDS).

Homicide is a death caused by injuries inflicted by one person with intent to injure or kill another by any means. Homicide can be classified as criminal or noncriminal, which includes death caused by negligence and those committed in self-defense.

Hospital occupancy is defined as the average daily census divided by the number of staffed hospital beds during a reporting period, usually one year.

Human biology includes all those aspects of health which are developed within the human body as a consequence of the basic biology of man and the make-up of the individual. There is no feasible population-based human biology indicator available now.

Incidence or Incidence Rate is the rate at which new cases of a disease or condition occur in a population, during a specific period of time. It is calculated using the following formula:

$$\frac{\text{Number of new cases in specific period}}{\text{Number of persons at risk of becoming cases in a specific period}} \times 1,000$$

The denominator often used is the mid-year population. Incidence measures rate of a disease/condition.

Infant Mortality is defined as the death of a child before its first birthday. Infant mortality is divided into two categories:

Neonatal Mortality refers to the death of a child aged 0-27 days.

Postneonatal Mortality refers to the death of a child aged 28-364 days.

Infant Mortality Rate is the measure used to evaluate infant mortality in a population. The infant mortality rate is calculated as follows:

$$\frac{\text{Number of infant deaths in specified time period}}{\text{Number of live births in that same specified time period}} \times 1,000$$

Intersection refers to the topological integration of two layers that preserves features common to both layers in GIS.

Intersection areas are areas exhibiting features common to two or more different layers in GIS.

Layer is a collection of similar geographic features – such as rivers, lakes, counties, or cities – of a particular area or place for display on a map. Layers are the basic components of overlay operations in GIS.

Licensed hospital beds represent the total number of inpatient beds in a hospital or group of hospitals on the day of certification inspection.

Lifestyle and behavior consists of the aggregation of decisions by individuals that affect their health. The behavioral risk factors domain in the MAPP Community Health Status Assessment list can be considered to belong to the lifestyle and behavior element.

Mammogram or Mammography refers to an X-ray technique for the breast with the purpose of early detection of breast problems, including cancer.

Maternal Mortality, according to the CDC, is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Maternal Mortality Ratio is the statistic used to measure maternal mortality in the population. It is calculated as follows:

$$\frac{\text{Number of maternal deaths in a specified time period}}{\text{Number of live births in that same time period}} \times 100,000$$

Mortality is death, the irreversible cessation of all of the following: (1) total cerebral function, (2) spontaneous function of respiratory system, and (3) spontaneous function of the circulatory system.

Neighborhood In this document, MHD considers Davidson County, TN as a community. Any geographical subdivision within Davidson County will be treated as a neighborhood.

Nosocomial infection relates to an infection acquired during a stay in a hospital or other health care facility. Nosocomial infections may also be called hospital-acquired infections. These infections were not present or incubating at the time of the admission to the hospital and were not the reason for hospitalization. Nosocomial infections also include infections that were acquired during hospitalization but did not appear until after discharge.

Overlaying refers to the process of stacking data layers on top of each other so that features in one layer can be analyzed in relation to features in other layers at the same geographical position in GIS.

Ozone is a colorless gas that can be found in the air we breathe. Ozone exists naturally in the earth's upper atmosphere, known as the stratosphere, where it shields the earth from the sun's ultraviolet rays. However, ozone is also found close to the earth's surface. This ground-level ozone is a harmful air pollutant. Ground level ozone forms through a complex chemical reaction involving volatile organic compounds, oxides of nitrogen, and sunlight. High ozone levels occur most frequently on hot summer afternoons when the air is stagnant. The ozone season in Middle Tennessee runs from May 1 until the end of September.

Pap Smear/Pap Test is a screening test for cervical cancer in which cells scraped from a woman's cervix are examined microscopically.

Particulate matter is any airborne finely divided solid or liquid material other than uncombined water.

Planning District: For public health planning purposes, Nashville has been divided into sixteen planning districts (PDs). Originally, there were fourteen planning districts. They were geographical subdivisions of the county adopted by the Metropolitan Planning Commission. Each planning district consists of one to sixteen 1990 census tracts. Due to noticeable changes in demographic factors in planning districts 7 and 10, it was decided in 1998 to divide planning districts 7 and 10 each into two subdivisions, i.e., PD 7 north (7a), PD 7 south (7b), PD 10 north (10a), and PD 10 south (10b).

Prevalence refers to the number of existing cases of a condition or disease in a population during a specific period of time. Prevalence measures the burden of a disease/condition.

Risk is the probability that an event will occur, e.g. that an individual will become ill or die within a stated period of time or age. Also, a non technical term encompassing a variety of measures of the probability of a generally unfavorable outcome.

SIDS is Sudden Infant Death Syndrome. The sudden death of a baby caused by unknown factors that have no specific symptoms.

Sigmoidoscopy is a test used for colon cancer screening in which the rectum, colon, and large bowel are examined with a flexible scope.

Sliver area (sliver polygon) is a small overlap area, or gap, along the borders of an area, which results from errors in overlaying or edge-matching several layers of maps in GIS.

Staffed hospital beds represent the number of inpatient beds in a hospital or group of hospitals for which there is adequate medical staff to provide care for patients in those beds.

Stroke is an interruption of the flow of blood to the brain. Stroke includes a group of diseases that affect the arteries of the central nervous system. Stroke results when an artery in the brain is either ruptured or clogged by a blood clot (thrombus), a wandering clot (embolus), or atherosclerotic plaque. Nerve cells in the affected part of brain die within minutes, often resulting in neurologic impairment.

Suicide is death as a result of violence directed against self.

Unintentional Injuries is another name for accidents and adverse effects. Refers to any unintentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen.

Vaccine is a product that consists of weakened or killed microorganisms (bacterium or virus) given for the prevention or treatment of infectious diseases. Vaccines may be administered by injection or by mouth. In the future, vaccines may be given by nasal spray, an aerosol that is received simply by breathing, or by a needle-less injection system.

Vaccine schedule is a plan of vaccinations that are recommended for specific ages and/or circumstances.

Vector-borne disease refers to a disease or infection that may be transmitted to humans by an invertebrate, animal without a spinal column. These invertebrates include ticks, mites, mosquitoes, and flies. Transmission may occur through a bite or through an area of trauma caused by scratching or rubbing.

Volatile Organic Compounds (VOC) are any compounds of carbon, excluding carbon monoxide, carbon dioxide, carbonic acid, metallic carbides or carbonates, and ammonium carbonate, which participate in atmospheric photochemical reactions. Several other carbon compounds have been excluded due to their negligible photochemical reactivity.

Watershed The American Heritage Dictionary defines watershed as the region draining into a river, river system, or other body of water.

YPLL is Years of Potential Life Lost. The number of years of life lost as the result of a death, before the age of 75.

Zipcodes are administrative units established by the United States Postal Service for the most efficient delivery of mail, and therefore, generally do not respect political or census statistical boundaries.

Technical Notes

Data Sources:

1. 2000 census population data were obtained from the U.S. Bureau of the Census, mainly from its website: <http://www.census.gov> during 2001 and 2002.
2. 1991-1998 population estimates were obtained from Tennessee Department of Health (TDH), Office of Health Statistics and Information.
3. Population data for public health planning districts were derived from 2000 census data (see “Health Planning District Population Estimation” in this Technical Note for detailed information).
4. Population data for Metro council districts were obtained from Metropolitan Planning Commission June 2002.
5. Social environment related population data were mainly obtained from the U.S. Bureau of the Census and Nashville Chamber of Commerce.
6. Physical environment related data were obtained from the Bureau of Environmental Health, Metropolitan Public Health Department of Nashville and Davidson County (MPHD).
7. Lifestyle and behavioral risk factor data were mainly from the Behavior Risk Factor Surveillance Survey (BRFSS) conducted by Division of Research and Evaluation of MPHD. Tennessee and U.S. BRFSS data were obtained from the CDC website: <http://www.cdc.gov/brfss/>
8. Drug abuse violation data were obtained from Metro Nashville Police Department and from the U.S. Department of Justice Uniform Crime Reports.
9. Health care systems related data were mainly from TDH.
10. Health status and quality of life data were obtained from the BRFSS conducted by MPHD.
11. Maternal and infant health related data were produced from natality and mortality datasets provided by TDH.
12. U. S. mortality data were obtained from U.S. Department of Health and Human Services, CDC, and National Center for Health Statistics (NCHS).
13. National objectives for 2010 were obtained from the U.S. Department of Health and Human Service’s publication, *Healthy People 2010*.
14. Mortality and natality data for Nashville, Tennessee, Shelby County, TN, Knox County, TN, and Hamilton County, TN were obtained from TDH, Office of Health Statistics and Information.
15. Nashville’s mortality data was compiled mainly from the original death certificates collected by the Vital Records Division of the Metropolitan Public Health Department of Nashville and Davidson County. Copies of death certificates occurring to Nashville/Davidson County residents in other counties and states are forwarded to the Tennessee Department of Health and included in the Davidson County residents’ mortality data set.
16. The morbidity data contained in this report for Nashville/Davidson, Hamilton, Knox, and Shelby Counties and Tennessee were obtained from the Tennessee Department of Health and from records kept at the Metropolitan Public Health Department.
17. Cancer incidence data were obtained from Tennessee Cancer Registry of TDH.

18. HIV and AIDS data were obtained from the HIV/AIDS Reporting System (HARS) at MPHD on March 19, 2002 and represent all cases reported to MPHD as of that date. HARS subsets used to prepare this report include the following:
 AIDS by date of report – %arptdate %aidscae and rcounty="DAVIDSON CO." and aidscae='1' and arptdate=%y[2000]
 AIDS by date of diagnosis – %aidscae and rcounty="DAVIDSON CO." and aidscae='1' and dxmoyr=%y[2000]
 HIV by date of report – %repcat and hcounty="DAVIDSON CO." and (repcat='1' and '3') and hposdate=%y[2000]
 HIV by date of diagnosis – %repcat and hcounty="DAVIDSON CO." and (repcat='1' and '3') hivpmoyr=%y[2000]
19. STD case data for Nashville was obtained from the MPHD National Electronic Surveillance System (NETSS) as of 10/18/2001 for 1995—2000 data, and as of 02/14/2002 for 2001 data. STD cases for Tennessee were obtained from the TDH as of 06/13/2002.
20. Data for leading health indicators relevant to adolescents was obtained from Nashville's 1999 Youth Behavior Risk Factor Survey. The survey was conducted on a representative sample of public school students in grades 9 through 12. To estimate vigorous physical activity, we used responses to the question regarding sweat-inducing exercise on three or more days of the past seven days. This is only a proxy measure of vigorous physical activity, which is defined in the Healthy People 2010 objective as activity that promotes cardiorespiratory fitness carried out on three or more days per week for 20 minutes or more per occasion.
21. The Healthy People 2010 target is for children 19-35 months old, however Nashville numbers are only available for children 24 months of age. We consider this an acceptable proxy as the immunizations required are the same for the national target and for Nashville's 24-month children surveyed. Healthy People objective 14-24 states that 80% of children between 19 and 35 months should be fully immunized by 2010.

Data Processing/Analysis:

1. For the purpose of mortality statistics, every death is attributed to one underlying condition, based on information reported on the death certificate. Death certificates are completed by the attending physicians, medical examiners, or coroners. The accuracy of data depends on the thoroughness of the individuals who complete the death certificates. In the case of sudden death without autopsy, the physician must make an educated guess as to the cause of death. Another cause of inaccuracy is the determination of which disease to considered the underlying cause of death. Only the underlying death is coded according to the International Classification of Diseases, Ninth Revision (ICD-9). Secondary causes that may have significantly contributed to death are not recorded. With increased life expectancy, people are more likely to die of multiple causes; therefore, a conservative approach should be taken when interpreting mortality information.
2. Causes of death are ranked according to the number of deaths (not rates) assigned to classifications in the 113 Select Causes of Death and 130 Select Causes of Infant Death. Leading causes of death are determined by this cause-of-death ranking.

3. Years of potential life lost (YPLL) is a measure of premature death. YPLL is presented in this report for the death of persons under 75 years of age because the average life expectancy in the United States is over 75 years. YPLL-75 is calculated using the following eight groups: under 1 year, 1-4 years, 15-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years, and 65-74 years. The number of deaths for each age group is multiplied by the years of life lost, calculated as the difference between age 75 years and the midpoint of the age group. For the eight age groups, the midpoints are 0.5, 7.5, 19.5, 29.5, 39.5, 49.5, 59.5, and 69.5. For example, the death of a person 15-24 years of age counts as 55.5 years of life lost. Years of potential life lost is derived by summing years of life lost over all age groups.
4. In some instances, analysis of age, race, and gender information in morbidity data was limited or forgone in this report due to the high percentage of reported cases whose age, race, and/or gender was unknown.
5. Notifiable disease data includes only reported cases. Because the notifiable disease reporting system is primarily a passive system, it is possible that only a portion of all notifiable diseases are actually reported. The percentage of reported notifiable diseases may vary from disease to disease. Diseases which cause the most severe clinical symptoms/illness are most likely to be reported. Reporting may also be influenced by the degree of testing required for diagnosis, the availability of laboratory facilities, and the cost of testing. Increased media coverage and subsequent increased public awareness pertaining to communicable diseases may increase reporting. Finally, the initiation of active surveillance techniques by health officials may lead to improved and more accurate reporting patterns. The Centers for Disease Control and Prevention case definitions were used to determine which reported diseases constituted a case and were reported to the Tennessee Department of Health. These definitions are used to standardize reporting nationally so that disease incidence may be compared among different geographic locations.
6. Race Groupings: Only white, black, and other races groupings could be done for most of the data analyzed in this report. Either numbers were too small or racial classification data was unreliable for other racial groups such as Hispanics, Asians, and Native Americans, and ethnicity data such as Hispanic status. Since the racial category "other" includes many different racial groups that may have different risks and behaviors, the results may be underestimates.
7. Nashville BRFSS: The data from each survey year were weighted so that the gender-race-age distribution of the respondents to the BRFSS would match the gender-race-age distribution of Nashville, TN in those years. Stratified analysis was done for covariates that are available not only in the BRFSS, but also in mortality and natality data for consistency across chapters of the *Health Nashville* report – these are gender, race, age, education, and marital status. Persons with unknown age were put in the 65 years and older group. Persons with unknown race were put in the other races group. Persons with unknown education were put in the less than high school diploma group. For marital status stratified information, persons with unknown marital status were excluded. The Nashville BRFSS sampling frame was designed to obtain approximately equal numbers of respondents from each health planning district. The Tennessee and U.S. BRFSS samples were obtained using a different sampling technique – the Mitofsky-Waksberg design – and were weighted to correct for geographic sampling bias, non-telephone coverage areas, and to match the age-by-sex or age-by-race/ethnicity-by-sex distribution of each state or region. For more information on the Tennessee and U.S. BRFSS sampling design, please go to their website at: <http://www.cdc.gov/brfss>. Because the Nashville survey uses a different sampling design than the state and national surveys, comparisons of Nashville to state and national data should be made carefully and not over-interpreted.

8. **Safety Belt Use:** The data was coded to combine the separate questions (#76 and 77) from 1996 to match the combined question regarding child restraints (#14) used in 1998. These questions ask how often the respondent or children under age 16 in his/her household wear safety belts or use child safety seats when driving or riding in a car. Possible answers were 1) always, 2) nearly always, 3) sometimes, 4) seldom, and 5) never. For simplicity these answers have been reduced to 1) always and 2) not always. Many publications use this method of dichotomizing the data.¹
9. **Bicycle Helmet Use:** The data for the bicycle helmet use section were obtained from the 1996 BRFSS question on how often the children in the household have worn bicycle helmets when riding a bicycle in the last year. The responses were classified into two groups – 1) always and 2) not always.
10. **Substance Abuse:** The category “drug-induced” mortality is defined by the National Center for Health Statistics to include deaths from mental and behavioral disorders due to psychoactive substance abuse; accidental poisoning by and exposure to drugs, medicaments, and biological substances; intentional self-poisonings (suicide) by and exposure to drugs, medicaments, and biological substances; assault (homicide) by drugs, medicaments, and biological substances; and poisoning of undetermined intent by and exposure to drugs, medicaments, and biological substances. This does not include accidents, homicides, or other causes that are indirectly related to drug use, or fetal or infant deaths due to mother’s drug use.
11. **Adult Immunizations:** The self-report data that we obtain from surveys such as the BRFSS can be biased in several ways. Misunderstood questions, words, or language, the desire to please the interviewee, memory difficulties, or variations in the way interviewers probe respondents all contribute to the potential for inaccurate data. Medicare data also contains inherent inaccuracies. Vaccination rates obtained from Medicare data are estimated based on claims that are filed. In some cases, physicians or others who administer influenza and pneumococcal vaccines may not file a claim with Medicare, perhaps because they do not know how to file claims, or the cost of filing the claim exceeds the compensation that they would receive from Medicare. In addition, adults less than 65 years old are not covered by Medicare in most cases, therefore vaccination estimates of the under 65 age group are not available using Medicare data. The following groups are at increased risk of complications from influenza, and are recommended to receive the influenza vaccine annually¹: persons aged 65 and older; residents of nursing homes and other chronic care facilities; adults and children (aged 6 months to 64 years) with chronic pulmonary or cardiovascular disorders, including asthma; adults and children who have required medical care in the previous year because of chronic metabolic diseases (diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression; children and adolescents receiving long term aspirin therapy and therefore at risk for Reye syndrome; and women who are or will be in the second or third trimester of pregnancy during the influenza season. Influenza vaccination is also recommended for adults aged 50-64 years old because of the increased prevalence of high-risk conditions, and for those who can transmit influenza to those at high risk (e.g. health care workers, nursing home employees, home health aids and household members of those at high risk). The following groups are recommended to receive the pneumococcal vaccine²: persons aged 65 and older should receive a one-time dose of pneumococcal vaccine (If the person was vaccinated before the age of 65 and it has been 5 or more years since the last vaccination, an additional dose should be administered.); adults and children (aged 2—64 years) with chronic pulmonary or cardiovascular disorders (**not**

including asthma), diabetes mellitus, immunocompromising conditions (including those on chemotherapy or corticosteroids), alcoholism, chronic liver disease, functional or anatomic asplenia (e.g. sickle-cell disease), or cerebrospinal fluid (CSF) leaks; residents of nursing homes or other chronic care facilities; and immunocompromised persons aged 2—10 should receive a single revaccination if more than three years have elapsed since receipt of the first dose.

Immunocompromised persons older than ten should receive a single revaccination if more than 5 years have elapsed since the first dose. Vaccination rates estimated from BRFSS data may be underestimates or overestimates of the true influenza and pneumococcal vaccination rates in Nashville in 1998 because they are based on self-reported vaccination status by survey respondents. The Medicare billing data rates are consistently lower than the rates obtained by self-report from the BRFSS. It is likely that the Medicare billing data underestimates the true influenza and pneumococcal vaccination rates in Nashville in 2000 because, in some cases, doctors may fail to bill Medicare for vaccines they administer resulting in the misclassification of that beneficiary as unvaccinated when they in fact did receive a vaccination. The disparity in the findings from the two different data sources could be a result of many factors. The populations being measured in the two different data sources may be very different and therefore it would be expected that the data would show different results. It is also possible that Nashville saw a large increase in pneumococcal vaccinations in 2000 compared to other areas, or that physicians in Nashville are more vigilant about billing Medicare for the vaccines they administer, than are doctors in other parts of the state and in the U.S.

12. Communicable diseases in this report are a selected group of notifiable diseases that are reported to the Metropolitan Public Health Department of Nashville and Davidson County (MPHD) regularly (other than AIDS/HIV, STDs, and TB). Other communicable diseases not listed in this report may be added as needed. Communicable diseases make up the largest portion of notifiable diseases, which are diseases that are required by law to be reported to the health department. Diseases that can be prevented by immunization include influenza, measles, mumps, polio, rubella (German measles), pertussis, diphtheria, tetanus, *Haemophilus influenzae* type b, hepatitis B, varicella (chickenpox), and others. Influenza, measles, diphtheria, mumps, pertussis, and tetanus are the six vaccine-preventable diseases listed regularly in this report, although others may be included as needed.
13. For MCH data, the calculation of statistics with small numbers often produces unstable results that demonstrate great fluctuation from year to year. Percentages are only calculated if the number of births is greater than 10. Groupings with less than 10 events are excluded from the analysis.
14. HIV and AIDS cases are tabulated two different ways: 1) by date of diagnosis and 2) by date of report to MHD. HIV cases had no AIDS defining conditions at the time of diagnosis. If HIV and AIDS were diagnosed simultaneously, the individual was counted only as an AIDS case.
15. HIV and AIDS cases include only individuals who were residents of Nashville at the time of diagnosis. For HIV cases, this means residence at first positive HIV-antibody test, and for AIDS cases, this means residence at diagnosis of the first AIDS indicator condition(s). Nonresidents were not included in this report, even if they became ill, were diagnosed, or received treatment in Nashville.
16. HIV and AIDS data presented in this report may not agree with data previously published by TDH or MPHD due to a number of factors. The number of cases will differ depending on whether date of diagnosis or date of report is used as the reference date. The number of cases by date of diagnosis will differ depending on the year the report is produced because of the time delay between when cases are diagnosed and when they are reported, sometimes several years. Specifically, rates

of disease based on date of diagnosis among Nashville residents differ from numbers previously published in the report “Sexually Transmitted Diseases in the 1990’s in Davidson County, Tennessee” because additional cases diagnosed in past years have since been reported. In addition, some reports may include individuals who are living with HIV/AIDS in Nashville and/or are receiving treatment and services in Nashville, even if they were diagnosed elsewhere, for the allocation of public health resources. Those individuals were excluded in this report.

17. According to the CDC, in Nashville there were 230 AIDS cases reported in 1999 and 340 AIDS cases reported in 2000, however, these numbers reflect reports from counties contained within the Nashville metropolitan statistical area (MSA). In addition to Davidson County, counties included in the Nashville MSA are: Cheatham, Dickson, Montgomery, Robertson, Rutherford, Sumner, Wilson, and Williamson Counties.
18. HIV and AIDS rates reported here are incidence rates per 100,000 population. The year 2000 population data used to calculate year 2000 rates was obtained from the U.S. Census Bureau. Population estimates for previous years used to calculate rates of disease from 1995—1999 were obtained from the TDH and are based on data provided by the University of Tennessee, Department of Sociology. Incidence rates are calculated as follows:

$$\text{Incidence Rate} = \frac{\text{Number of new cases (reported or diagnosed) in year}}{\text{Number of people at risk during the year}} \times 100,000$$

19. The HIV/AIDS dataset does not allow for a separate ethnic identity, separate from race, therefore, for the purposes of analysis, race was reported as black, white or other, with the “other” group including identified Hispanics.
20. HIV information for the entire U.S. includes only cases reported from the 34 areas with laws or regulations requiring confidential reporting by name of individuals with confirmed HIV infection.
21. The number of STD cases reported here may differ from numbers previously published by Tennessee or by the U.S. government because of differences in data collection and reporting practices. Many of the race group differences are attributable to the manner in which ethnicity and race are reported by different entities, for example, the state of Tennessee includes all those of Hispanic origin in the “Other” race category, whereas CDC and MPHD include Hispanics as a unique race/ethnicity category.
22. STD rates for Nashville published in this document may differ from rates previously published by Tennessee or by the U.S. government because of differences in the denominator used to calculate rates for reasons detailed previously, and because of differences in the population data used to calculate disease rates.
23. STD rates reported here are incidence rates per 100,000 population. The population data used to calculate year 2000 STD rates for Nashville and Tennessee was obtained from the U.S. Census Bureau. Year 2001 rates were also calculated using year 2000 census data because estimates for 2001 were not available at the time of analysis. Population data used to calculate STD rates for 1995—1999 are estimates based on the 1990 census obtained from the TDH and provided by the University of Tennessee, Department of Sociology. Incidence rates are calculated as follows:

$$\text{Incidence Rate} = \frac{\text{Number of new cases (reported or diagnosed) in year}}{\text{Number of people at risk during year}} \times 100,000$$

24. Published STD rates reported from CDC are calculated using intercensal population estimates provided by the U.S. Census Bureau for 1995–1999 rates, and for year 2000 rates because year 2000 census data had not been released at the time of analysis. See individual publications for detailed information on the calculation of national STD rates.

Health Planning District Population Estimation:

1. **Background:** The population numbers for MPHD Health Planning Districts were obtained by performing an overlay analysis with a geographic information system (GIS). A GIS is a computer-based tool used to analyze information that can be associated with a known location on the earth, or in our case, in Nashville. Within a GIS, information that describes the location of geographic features such as streets, fire stations, census tracts, or zip code areas, is grouped into categories based on the particular type of feature it is. For instance, all fire stations would be in the same “fire station” category. These categories are called layers. Additional information about the geographic features can also be stored in each layer. In the fire station example, additional information might be the number of staff at each station, or the number of trucks.

Using a GIS, you can add layers to a map of the city to show the exact location of the features (e.g. fire station) in the city. In the fire station example, by displaying the number of fire trucks at each fire station on the map, one can identify which areas of the city have the most fire trucks available. By adding two or more layers to a single map, you can see different types of features at the same time and learn how they are related to each other. If a fire station layer was displayed with a layer containing information about schools, and a layer of streets and highways, it would be possible to determine the number of fire stations and fire trucks near each school, as well as the streets that would need to be taken to get from each fire station to a particular school. This process is called overlay analysis.

2. **Methods:** Population demographics for health planning districts were estimated by overlaying U.S. Census Bureau census tract areas and population numbers, with the major assumption that populations are equally distributed within each census tract.

For the 2000 Census the U.S. Census Bureau divided Davidson County, Tennessee into 144 contiguous areas called census tracts. As designed by the U.S. Census Bureau these 144 census tracts cover all of Davidson County and do not include any areas that are not Davidson County. Similarly, the MPHD divides Davidson County into 16 contiguous health planning districts, while the Metro Council divides Davidson County into 35 contiguous council districts. The criteria used to establish boundaries for census tracts are different than the criteria used to establish boundaries for health planning districts or council districts. Both health planning districts and council districts are larger geographic entities than census tracts.

Therefore, a single health planning district or a single council district tends to cover the same geographic area as multiple census tracts, and can contain entire census tracts and/or portions of several different census tracts. The methodology was used in this analysis, with a health planning district layer.

3. **Health Planning District Population Estimation:** To estimate the population of the health planning districts (Figure TN1), the Davidson County census tracts layer

(Figure TN2) was overlaid with the health planning districts layer (Figure TN3). Using a GIS, a new “intersection” layer was generated based on the overlay, containing the geographic information of both the census tracts layer and the health planning districts layer (Figure TN4). Each area in the new intersect layer represented a census tract, or portion of a census tract, which overlapped with a portion of a health planning district. The proportion of each census tract falling within different health planning districts was calculated by dividing the total area of the census tract by the area of each census tract part falling within a different health planning district (Figure TN5). If the entire census tract fell within the boundary of the health planning district, then the proportion of the census tract falling within the health planning district was 100%. If the census tract was divided among several health planning districts, then the proportion of the entire census tract falling within each of the different health planning districts summed to 100%. In geographic terms, following the intersect overlay of the census tract layer and the health planning district layer, each census tract or census tract portion is called an “intersect area”.

To obtain population and demographic data for each of the health planning districts, the population of each intersect area was first calculated. This was done by multiplying the intersect area’s census tract proportion by the entire census tract population (Table TN1). Finally, the population estimates of the intersect areas contained within each of the health planning districts were summed to obtain total population estimates for each of the health planning districts (Table TN2).

4. **Limitations:** One limitation of this methodology is that a uniform population density is assumed throughout each census tract and health planning district. In other words, it is assumed that the people represented by the demographic data are just as likely to reside in one portion of a census tract or health planning district as they are in another portion of the same geographic feature. Water bodies or other regions where it is known people do not live were not taken into account. In addition, rounding error and “sliver areas” resulted in the total population estimates for all of the health planning districts summed together (i.e. total Davidson County population based on the sum of health planning districts) to be slightly different from the total population of all census tracts summed together.

Rounding error is introduced when an intersect area’s census tract proportion is applied to a population count for a census tract. If the intersect area is equal to an entire census tract (the intersect area’s census tract proportion is 100%) then the entire population of that census tract will be assigned to the same health planning district. However, if an intersect area represents only a portion of the census tract, then the population for that intersect area is a decimal value rather than a whole number, resulting from the multiplication of the intersect area’s census tract proportion with the entire census tract population. When the population of all of the intersect areas within each health planning district are added together, fractions of individuals are summed together to represent new whole individuals. The end-result of the summation is also a decimal value, which must be rounded to the nearest whole number to represent population counts.

Sliver areas are introduced when the boundaries for census tracts and health planning districts happen to coincide, generally along street centerlines or the county boundary. Because the GIS data (map) for census tracts and health planning districts are from different sources, the boundaries do not overlay precisely and extremely small intersect areas result. For this analysis, sliver areas smaller than 0.05% of the total census tract area were discarded from the intersection layer.

To correct some of the errors caused by rounding and sliver polygons, health planning district population numbers were rescaled to equal the total population of Davidson County when summed, using the following formula:

$$\frac{\text{Sum of all Health Planning District Populations}}{\text{Health Planning District Total Population}} \times \text{Davidson County Census Population}$$

As a result of rescaling, underestimates of the total population would result in the addition of population to each health planning district, proportional to the population of each health planning district. Similarly, overestimates of the population would result in proportional subtraction of population counts from each health planning district.

It is important to remember that these numbers are estimates and may not be representative of the true population distribution in any of these areas. U.S. Census Bureau data should be referenced when using the total Davidson County population.

Planning District:

For public health planning purposes, Nashville has been divided into sixteen planning districts (PDs). Originally, there were fourteen planning districts. They were geographical subdivisions of the county adopted many years ago by the Metropolitan Planning Commission. Each planning district consists of one to sixteen 1990 census tracts. Due to noticeable changes in demographic factors in planning districts 7 and 10, it was decided in 1998 to divide planning districts 7 and 10 each into two subdivisions, i.e., PD 7 south (7b), PD 7 north (7a), PD 10 south (10b), and PD 10 north (10a).

Councilmanic District:

Thirty-five (35) councilmanic districts were created by the Charter of the Metropolitan Government of Nashville and Davidson County, Tennessee. According to article 3 of the Charter, "There shall be thirty-five (35) councilmanic districts in the metropolitan government, which are hereby created and established in accordance with the detailed descriptions thereof by metes and bounds as set forth in Appendix Two hereto attached as a part of this Charter." "The descriptions of the councilmanic districts given in this appendix were originally promulgated in Bill No. 81-701, § adopted Oct. 6, 1981. Descriptions of Districts 1 — 35 were entirely amended in the redistricting plan adopted by referendum vote on Sept. 5, 1991. " In this report, it refers as " Council District (1991-2002)". Descriptions of Districts 1 — 35 were entirely amended again in the

Figure TN1. Health Planning Districts in Nashville, TN

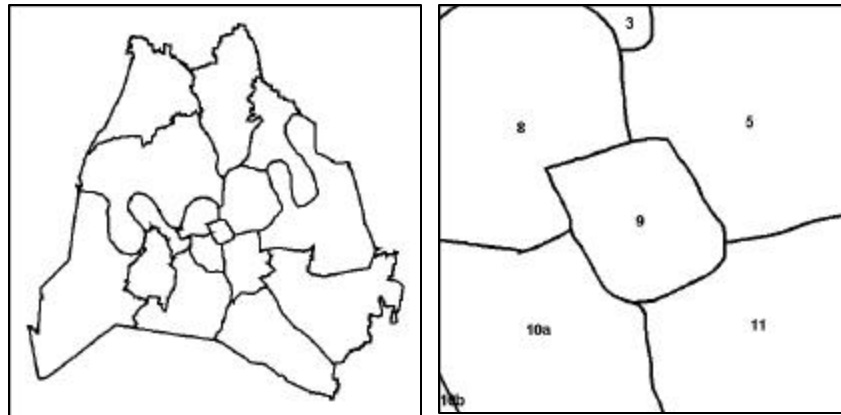


Figure TN2. Census Tracts in Nashville, TN

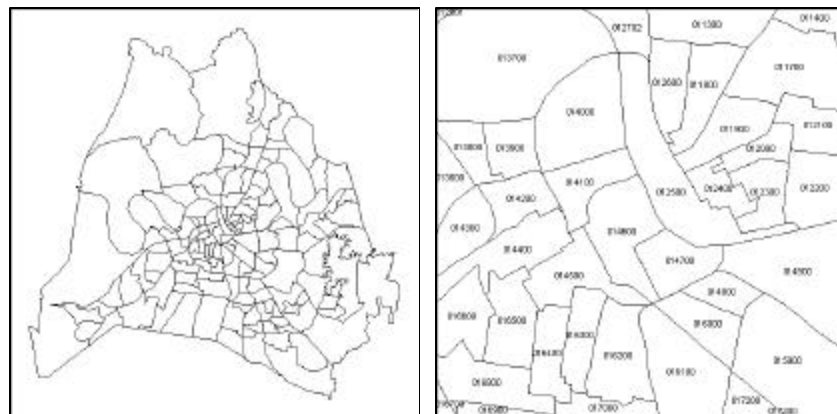


Figure TN3. Overlay of Health Planning District and Census Tract Layers



Figures TN 4, 5. Intersection of Health Planning District and Census Tract Layers and Calculation of Intersection Area Proportions



Table TN1. Calculation of Intersect Area Population Values

Intersection ID	Census Tract	Health PD	Area Percentage	Tract Population	Intersection Population
1	012500	5	31%	234	72.54
2	012500	9	54%	234	126.36
3	012500	5	15%	234	35.1
4	014100	9	100%	530	530
5	014500	10a	63%	357	224.91
6	014500	9	37%	357	132.09
7	014600	9	100%	2306	2306
8	014700	9	100%	308	308

Table TN2. Calculation of Health Planning District Population Values

Intersection ID	Census Tract	Health PD	Area Percentage	Tract Population	Intersection Population
2	012500	9	54%	234	126.36
4	014100	9	100%	530	530
6	014500	9	37%	357	132.09
7	014600	9	100%	2306	2306
8	014700	9	100%	308	308
Total Population for Health Planning District 9:					3402.45

redistricting plan based on census 2000 data and was adopted in November 12, 2001. In this report, it is referred to as “ Council District (2003)”. Council District (2003) will take effect after the 2003 metropolitan council election.

Residential Data:

Data presented in this report is for Nashville/Davidson County residents only.

Software:

Data were analyzed using Microsoft Excel 97; SAS for Windows, Version v.6.12; and SPSS v.9.0 for Windows. Maps were produced using ArcGIS v.8.2. Data presentation preparations were done in Microsoft Excel 97 and Microsoft Word 97. The layout of this report was done in Adobe PageMaker v.7.0.

Technical Notes References:

1. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices. Morbidity and Mortality Weekly Report 2002; 51(RR-3): 1-31.
2. CDC. Prevention of pneumococcal disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report 1997; 46(RR-8): 1-24.

ICD-9 and ICD-10 Codes

Table A. Comparable Category Codes for Nashville's Leading Causes of Death, according to the Ninth and Tenth Revisions of the International Classification of Diseases*

Cause of death (Based on the Tenth Revision, International Classification of Diseases, 1992)	Category codes according to the Tenth Revision (ICD-10)	Category codes according to the Ninth Revision (ICD-9)
Septicemia	A40-A41	038
Human immunodeficiency virus (HIV) related disease	B20-B24	*042-*044
Malignant neoplasms (Cancer)	C00-C97	140-208
Diabetes mellitus	E10-E14	250
Alzheimer's disease	G30	331.0
Diseases of the heart	I00-I09, I11, I13, I20-I51	390-398, 402, 404, 410-429
Essential (primary) hypertension and hypertensive renal disease (Hypertension)	I10, I12	401, 403
Cerebrovascular diseases	I60-I69	430-434, 436-438
Other disorders of the circulatory system	I71-I78	441-448
Influenza and pneumonia	J10-J18	480-487
Chronic lower respiratory diseases	J40-J47	490-494, 496
Other diseases of the respiratory system	J00-J06, J30-J39, J67, J70-J98	034.0, 460-465, 470-478, 495, 508-519
Chronic liver disease and cirrhosis	K70, K73-74	571
Nephritis, nephrotic syndrome, and nephrosis	N00-N07, N17-N19, N25-N27	580-589
Pregnancy, childbirth, and the puerperium (Perinatal conditions)	O00-O99	630-676
Congenital malformations, deformations, and chromosomal abnormalities (Congenital anomalies)	Q00-Q99	740-759
Accidents (unintentional injuries)	V01-X59, Y85-Y86	E800-E869, E880-E929
Intentional self-harm (suicide)	X60-X84, Y87.0	E950-E959
Assault (homicide)	X85-Y09, Y87.1	E960-E969
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (Unclassified clinical and laboratory findings)	R00-R99	780-799
Infant Causes of Death		
Disorders related to short gestation and low birth weight, not elsewhere classified	P07	765
Respiratory distress of newborn	P22	769
Bacterial sepsis of newborn	P36	771.8
Neonatal hemorrhage	P50-P52, P54	772
Congenital malformations of heart	Q20-Q24	745-746
Other congenital malformations of nervous system	Q01-Q02, Q04, Q06-Q07	742.0-742.2, 742.4-742.9
Newborn affect by chorioamnionitis*	P02.7	762.7
Interstitial emphysema and related conditions originating in the perinatal period	P25	770.2
Sudden Infant Death Syndrome (SIDS)	R95	798.0
Other and unspecified diseases of respiratory system	J00-J06, J30-J39, J67, J70-J98	034.0, 460-465, 470-478, 495, 508-519
Pneumonia	J12-J18	480-486
Chronic respiratory disease originating in the perinatal period	P27	770.7
Accidental suffocation and strangulation in bed	W75	E913.0

* Causes of death are not ranked in order of predominance. For a complete list see National Vital Statistics Report, V49, No.8, September 21, 2001

Table B. List of 113 Selected Causes of Death (ICD-10)

Number	Cause of Death (Tenth Revision, International Classification of Diseases, 1992)	ICD-10 Codes
1#	Salmonella infections	A01-A02
2#	Shigellosis and amebiasis	A03,A06
3	Certain other intestinal infections	A04,A07-A09
#	Tuberculosis	A16-A19
4	Respiratory tuberculosis	A16
5	Other tuberculosis	A17-A19
6#	Whooping cough	A37
7#	Scarlet fever and erysipelas	A38,A46
8#	Meningococcal infection	A39
9#	Septicemia	A40-A41
10#	Syphilis	A50-A53
11#	Acute poliomyelitis	A80
12#	Arthropod-borne viral encephalitis	A83-A84,A85.2
13#	Measles	B05
14#	Viral hepatitis	B15-B19
15#	Human immunodeficiency virus (HIV) disease	B20-B24
16#	Malaria	B50-B54
17	Other and unspecified infectious and parasitic diseases and their sequelae	A00,A05,A20-A36,A42-A44,A48-A49,A54-A79, A81-A82,A85.0-A85.1,A858,A86-B04,B06-B09,B25-B49,B55-B99
#	Malignant neoplasms	C00-C97
18	Malignant neoplasms of lip, oral cavity and pharynx	C00-C14
19	Malignant neoplasm of esophagus	C15
20	Malignant neoplasm of stomach	C16
21	Malignant neoplasms of colon, rectum and anus	C18-C21
22	Malignant neoplasms of liver and intrahepatic bile ducts	C22
23	Malignant neoplasm of pancreas	C25
24	Malignant neoplasm of larynx	C32
25	Malignant neoplasms of trachea, bronchus and lung	C33-C34
26	Malignant melanoma of skin	C43
27	Malignant neoplasm of breast	C50
28	Malignant neoplasm of cervix uteri	C53
29	Malignant neoplasms of corpus uteri and uterus, part unspecified	C54-C55

See note at end of table.

Table B. List of 113 Selected Causes of Death (ICD-10)

Number	Cause of Death (Tenth Revision, International Classification of Diseases, 1992)	ICD-10 Codes
30	Malignant neoplasm of ovary	C56
31	Malignant neoplasm of prostate	C61
32	Malignant neoplasms of kidney and renal pelvis	C64-C65
33	Malignant neoplasm of bladder	C61
34	Malignant neoplasms of meninges, brain and other parts of central nervous system	C70-C72
	Malignant neoplasms of lymphoid, hematopoietic and related tissue	C81-C96
35	Hodgkin's disease	C81
36	Non-Hodgkin's lymphoma	C82-C85
37	Leukemia	C91-C95
38	Multiple myeloma and immunoproliferative neoplasms	C88,C90
39	Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue	C96
40	All other and unspecified malignant neoplasms	C11,C23-C24,C26-C31, C37-C41,C44-C49,C51-C52,C57-C60,C62-C63,C66,C68-C69,C73-C80,C97
41#	In situ neoplasms benign neoplasms and neoplasms of uncertain or unknown behavior	D00-D48
42#	Anemias	D50-D64
43#	Diabetes mellitus	E10-E14
#	Nutritional deficiencies	E40-E64
44	Malnutrition	E40-E46
45	Other nutritional deficiencies	E50-E64
46#	Meningitis	G00,G03
47#	Parkinson's disease	G20-G21
48#	Alzheimers disease	G30
	Major cardiovascular diseases	I00-I78
#	Diseases of heart	I00-I09,I11,I13,I20-I51
49	Acute rheumatic fever and chronic rheumatic heart diseases	I00-I09
50	Hypertensive heart disease	I11
51	Hypertensive heart and renal disease	I13
	Ischemic heart diseases	I20-I25
52	Acute myocardial infarction	I21-I22
53	Other acute ischemic heart diseases	I24
	Other forms of chronic ischemic heart disease	I20, I25

See note at end of table.

Table B. List of 113 Selected Causes of Death (ICD-10)

Number	Cause of Death (Tenth Revision, International Classification of Diseases, 1992)	ICD-10 Codes
54	Atherosclerotic cardiovascular disease, so described	I25.0
55	All other forms of chronic ischemic heart disease	I20,I25.1-I25.9
	Other heart diseases	I26-I51
56	Acute and subacute endocarditis	I33
57	Diseases of pericardium and acute myocarditis	I30-I31,I40
58	Heart failure	I50
59	All other forms of heart disease	I26-I28,I34-I38,I42-I49,I51
60#	Essential (primary) hypertension and hypertensive renal disease	I10,I12
61#	Cerebrovascular diseases	I60-I69
62#	Atherosclerosis	I70
	Other diseases of circulatory system	I71-I78
63#	Aortic aneurysm and dissection	I71
64	Other diseases of arteries, arterioles and capillaries	I72-I78
65	Other disorders of circulatory system	I80-I99
#	Influenza and pneumonia	J10-J18
66	Influenza	J10-J11
67	Pneumonia	J12-J18
	Other acute lower respiratory infections	J20-J22
68#	Acute bronchitis and bronchiolitis	J20-J21
69	Unspecified acute lower respiratory infection	J22
#	Chronic lower respiratory diseases	J40-J47
70	Bronchitis, chronic and unspecified	J40-J42
71	Emphysema	J43
72	Asthma	J45-J46
73	Other chronic lower respiratory diseases	J44,J47
74#	Pneumoconioses and chemical effects	J60-J66,J68
75#	Pneumonitis due to solids and liquids	J69
76	Other diseases of respiratory system	J00-J06J30-J39,J67,J70-J98
77#	Peptic ulcer	K25-K28
78#	Diseases of appendix	K35-K38
79#	Hernia	K40-K46
#	Chronic liver disease and cirrhosis	K70,K73-K74
80	Alcoholic liver disease	K70

See note at end of table.

Table B. List of 113 Selected Causes of Death (ICD-10)

Number	Cause of Death (Tenth Revision, International Classification of Diseases, 1992)	ICD-10 Codes
81	Other chronic liver disease and cirrhosis	K73-K74
82#	Cholelithiasis and other disorders of gallbladder	K80-K82
#	Nephritis nephrotic syndrome and nephrosis	N00-N07, N17-N19, N25-N27
83	Acute and rapidly progressive nephritic and nephrotic syndrome	N00-N01, N04
84	Chronic glomerulonephritis, nephritis and nephritis not specified as acute or chronic, and renal sclerosis unspecified	N02-N03, N05-N07 ,N26
85	Renal failure	N17-N19
86	Other disorders of kidney	N25, N27
87#	Infections of kidney	N10-N12, N13.6, N15.1
88#	Hyperplasia of prostate	N40
89#	Inflammatory diseases of female pelvic organs	N70-N76
#	Pregnancy, childbirth and the puerperium	O00-O99
90	Pregnancy with abortive outcome	O00-O07
91	Other complications of pregnancy, childbirth and the puerperium	O10-O99
92#	Certain conditions originating in the perinatal period	P00-P96
93#	Congenital malformations, deformations and chromosomal abnormalities	Q00-Q99
94	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	R00-R99
95	All other diseases (Residual)	D65-E07,E15-E34, E65-F99,G04-G12,G23-G25,G31-H93, K00-K22, K29-K31, K50-K66, K71-K72, K75-K76, K83-M99, N13.0-N13.5, N13.7-N13.9, N14, N15.0, N15.8-N15.9, N20-N23, N28-N39, N41-N64, N80-N98
#	Accidents (unintentional injuries)	V01-X59,Y85-Y86
	Transport accidents	V01-V99,Y85
96	Motor vehicle accidents	V02-V04,V09.0,V09.2,V12-V14,V19.0-V19.2,VI9.4-VI9.6, V20-V79, V80.3-V80.5, V810-V811, V820-V821, V83-V86, V87.0-V87.8, V88.0-V88.8,V89.0,V89.2
97	Other land transport accidents	V01,V05-V06,V09.1,V09.3-V09.9,V10-V11,V15-V18,V19.3, V19.8-V19.9, V80.0-V80.2, V80.6-V80.9, V81.2-V81.9, V82.2-V82.9, V87.9, V88.9, V89.1, V89.3, V89.9
98	Water, air, and space, and other and unspecified transport accidents and their sequelae	V90-V99,Y85
	Nontransport accidents	W00-X59,Y86
99	Falls	W00-W19

See note at end of table.

Table B. List of 113 Selected Causes of Death (ICD-10)

Number	Cause of Death (Tenth Revision, International Classification of Diseases, 1992)	ICD-10 Codes
100	Accidental discharge of firearms	W32-W34
101	Accidental drowning and submersion	W65-W74
102	Accidental exposure to smoke fire and flames	X00-X09
103	Accidental poisoning and exposure to noxious substances	X40-X49
104	Other and unspecified nontransport accidents and their sequelae	W20-W31, W35-W64, W75-W99, X10-X39, X50-X59, Y86
#	Intentional self-harm (suicide)	X60-X84, Y870
105	Intentional self-harm (suicide) by discharge of firearms	X72-X74
106	Intentional self-harm (suicide) by other and unspecified means and their sequelae	X60-X71, X75-X84, Y87.0
#	Assault (homicide)	X85-Y09, Y87.1
107	Assault (homicide) by discharge of firearms	X93-X95
108	Assault (homicide) by other and unspecified means and their sequelae	X85-X92, X96-Y09, Y87.1
109#	Legal intervention	Y35, Y89.0
	Events of undetermined intent	Y10-Y34, Y87.2, Y89.9
110	Discharge of firearms undetermined intent	Y22-Y24
111	Other and unspecified events of undetermined intent and their sequelae	Y10-Y21, Y25-Y34, Y87.2, Y89.9
112#	Operations of war and their sequelae	Y36, Y89.1
113#	Complications of medical and surgical care	Y40-Y84, Y88

Note: The causes listed with # in the number column are ranked to give the leading causes of death for certain population groups

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, US Department of Health and Human Services

Table C. List of 130 Selected Causes of Infant Death (ICD-10)

Number	Cause of death (Tenth Revision,International Classification of Diseases ,1992)	ICD-10 Codes
	Certain infectious and parasitic diseases	A00 -B99
1	Certain intestinal infectious diseases	A00 -A08
2#	Diarrhea and gastroenteritis of infectious origin	A09
3#	Tuberculosis	A16 -A19
4#	Tetanus	A33,A35
5#	Diphtheria	A36
6#	Whooping cough	A37
7#	Meningococcal infection	A39
8#	Septicemia	A40 -A41
9#	Congenital syphilis	A50
10#	Gonococcal infection	A54
	Viral diseases	A80 -B34
11#	Acute poliomyelitis	A80
12#	Varicella (chickenpox	B01
13#	Measles	B05
14#	Human immunodeficiency virus (HIV)disease	B20 -B24
15#	Mumps	B26
16	Other and unspecified viral diseases	A81 -B00,B02 -B04,B06 -B19,B25,B27 -B34
17#	Candidiasis	B37
18#	Malaria	B50 -B54
19#	Pneumocystosis	B59
20	All other and unspecified infectious and parasitic diseases	A20 -A32,A38,A42 -A49,A51 -A53,A55 -A79,B35 -B36,B38 -B49,B55 -B58,B60 -B99
	Neoplasms	C00 -D48
#	Malignant neoplasms	C00 -C97
21	Hodgkin 's disease and non-Hodgkin 's lymphomas	C81 -C85
22	Leukemia	C91 -C95
23	Other and unspecified malignant neoplasms	C00 -C80,C88 -C90,C96 -C97
24#	In situ neoplasms,benign neoplasms and neoplasms of uncertain or unknown behavior	D00 -D48
#	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	D50 -D89
25	Anemias	D50 -D64
26	Other diseases of blood and blood-forming organs	D65 -D76

Table C. List of 130 Selected Causes of Infant Death (ICD-10)

27	Certain disorders involving the immune mechanism	D80 -D89
	Endocrine,nutritional and metabolic diseases	E00 -E88
28#	Short stature,not elsewhere classified	E34.3
29#	Malnutrition and other nutritional deficiencies	E40 -E64
30#	Cystic fibrosis	E84
31#	Volume depletion,disorders of fluid,electrolyte and acid -base balance	E86 -E87
32	All other endocrine,nutritional and metabolic diseases	E00 -E32,E34.0 -E34.2,E34.4 -E34.9,E65 -E83,E85,E88
	Diseases of the nervous system	G00 -G98
33#	Meningitis	G00,G03
34#I	Infantile spinal muscular atrophy,type I (Werdnig-Hoffman	G12.0
35#	Infantile cerebral palsy	G80
36#	Anoxic brain damage,not elsewhere classified	G93.1
37	Other diseases of nervous system	G04,G06 -G11,G12.1 -G12.9,G20 -G72,G81 -G92,G93.0,G93.2 -G93.9,G95 -G98
38#	Diseases of the ear and mastoid process	H60 -H93
#	Diseases of the circulatory system	I00 -I99
39	Pulmonary heart disease and diseases of pulmonary circulation	I26 -I28
40	Pericarditis,endocarditis and myocarditis	I30,I33,I40
41	Cardiomyopathy	I42
42	Cardiac arrest	I46
43	Cerebrovascular diseases	I60 -I69
44	All other diseases of circulatory system	I00 -I25,I31,I34 -I38,I44 -I45,I47 -I51,I70 -I99
	Diseases of the respiratory system	J00 -J98
45#	Acute upper respiratory infections	J00 -J06
#	Influenza and pneumonia	J10 -J18
46	Influenza	J10 -J11
47	Pneumonia	J12 -J18
48#	Acute bronchitis and acute bronchiolitis	J20 -J21
49#	Bronchitis,chronic and unspecified	J40 -J42
50#	Asthma	J45 -J46
51#	Pneumonitis due to solids and liquids	J69
52	Other and unspecified diseases of respiratory system	J22,J30 -J39,J43 -J44,J47 -J68,J70 -J98
	Diseases of the digestive system	K00 -K92
53#	Gastritis,duodenitis,and noninfective enteritis and colitis	K29,K50 -K55

Table C. List of 130 Selected Causes of Infant Death (ICD-10)

54#	Hernia of abdominal cavity and intestinal obstruction without hernia	K40 -K46,K56
55	All other and unspecified diseases of digestive system	K00 -K28,K30 -K38,K57 -K92
	Diseases of the genitourinary system	N00 -N98
56#	Renal failure and other disorders of kidney	N17 -N19,N25,N27
57	Other and unspecified diseases of genitourinary system	N00 -N15,N20 -N23,N26,N28 -N98
57	Certain conditions originating in the perinatal period	P00 -P96
	Newborn affected by maternal factors and by complications of pregnancy,labor and delivery	P00 -P04
58#	Newborn affected by maternal hypertensive disorders	P00.0
59#	Newborn affected by other maternal conditions which may be unrelated to present pregnancy	P00.1 -P00.9
#	Newborn affected by maternal complications of pregnancy	P01
60	Newborn affected by incompetent cervix	P01.0
61	Newborn affected by premature rupture of membranes	P01.1
62	Newborn affected by multiple pregnancy	P01.5
63	Newborn affected by other maternal complications of pregnancy	P01.2 -P01.4,P01.6 -P01.9
#	Newborn affected by complications of placenta,cord and membranes	P02
64	Newborn affected by complications involving placenta	P02.0 -P02.3
65	Newborn affected by complications involving cord	P02.4 -P02.6
66	Newborn affected by chorioamnionitis	P02.7
67	Newborn affected by other and unspecified abnormalities of membranes	P02.8 -P02.9
68#	Newborn affected by other complications of labor and delivery	P03
69#	Newborn affected by noxious influences transmitted via placenta or breast milk	P04
	Disorders related to length of gestation and fetal malnutrition	P05 -P08
70#	Slow fetal growth and fetal malnutrition	P05
#	Disorders related to short gestation and low birth weight,not elsewhere classified	P07
71	Extremely low birth weight or extreme immaturity	P07.0,P07.2
72	Other low birth weight or preterm	P07.1,P07.3
73#	Disorders related to long gestation and high birth weight	P08
74#	Birth trauma	P10 -P15
#	Intrauterine hypoxia and birth asphyxia	P20 -P21
75	Intrauterine hypoxia	P20
76	Birth asphyxia	P21
77#	Respiratory distress of newborn	P22

Table C. List of 130 Selected Causes of Infant Death (ICD-10)

	Other respiratory conditions originating in the perinatal period	P23 -P28
78#	Congenital pneumonia	P23
79#	Neonatal aspiration syndromes	P24
80#	Interstitial emphysema and related conditions originating in the perinatal period	P25
81#	Pulmonary hemorrhage originating in the perinatal period	P26
82#	Chronic respiratory disease originating in the perinatal period	P27
83#	Atelectasis	P28.0 -P28.1
84	All other respiratory conditions originating in the perinatal period	P28.2 -P28.9
84	Infections specific to the perinatal period	P35 -P39
85#	Bacterial sepsis of newborn	P36
86#	Omphalitis of newborn with or without mild hemorrhage	P38
87	All other infections specific to the perinatal period	P35,P37,P39
	Hemorrhagic and hematological disorders of newborn	P50 -P61
88#	Neonatal hemorrhage	P50 -P52,P54
89#	Hemorrhagic disease of newborn	P53
90#	Hemolytic disease of newborn due to isoimmunization and other perinatal jaundice	P55 -P59
91#	Hematological disorders	P60 -P61
92#	Syndrome of infant of a diabetic mother and neonatal diabetes mellitus	P70.0 -P70.2
93#	Necrotizing enterocolitis of newborn	P77
94#	Hydrops fetalis not due to hemolytic disease	P83.2
95	Other perinatal conditions	P29,P70.3 -P76,P78 -P81,P83.0 -P83.1,P83.3 -P96
#	Congenital malformations,deformations and chromosomal abnormalities	Q00 -Q99
96	Anencephaly and similar malformations	Q00
97	Congenital hydrocephalus	Q03
98	Spina bifida	Q05
99	Other congenital malformations of nervous system	Q01 -Q02,Q04,Q06 -Q07
100	Congenital malformations of heart	Q20 -Q24
101	Other congenital malformations of circulatory system	Q25 -Q28
102	Congenital malformations of respiratory system	Q30 -Q34
103	Congenital malformations of digestive system	Q35 -Q45
104	Congenital malformations of genitourinary system	Q50 -Q64
105	Congenital malformations and deformations of musculoskeletal system,limbs and integument	Q65 -Q85
106	Down 's syndrome	Q90

Table C. List of 130 Selected Causes of Infant Death (ICD-10)

107	Edward 's syndrome	Q91.0 -Q91.3
108	Patau 's syndrome	Q91.4 -Q91.7
109	Other congenital malformations and deformations	Q10 -Q18,Q86 -Q89
110	Other chromosomal abnormalities,not elsewhere classified	Q92 -Q99
	Symptoms,signs and abnormal clinical and laboratory findings,not elsewhere classified	R00 -R99
111#	Sudden infant death syndrome	R95
112	Other symptoms,signs and abnormal clinical and laboratory findings,not elsewhere classified	R00 -R53,R55 -594,R96 -R99
113	All other diseases	F01 -F99,H00 -H57,L00 -M99
	External causes of mortality	V01 -Y89
#	Accidents (unintentional injuries	V01 -X59
	Transport accidents	V01 -V99
114	Motor vehicle accidents	V02 -V04,V09.0,V09.2,V12 -V14,V19.0 -V19.2,V19.4 -V19.6,V20 -V79,V80.3 -V80.5,V81.0 -V81.1,V82.0 -V82.1,V83 -V86, V87.0 -V87.8,V88.0 -V88.8,V89.0,V89.2
115	Other and unspecified transport accidents	V01,V05 -V06,V09.1,V09.3 -V09.9,V10 -V11,V15 -V18,V19.3,V19.8,V19.9,V80.0 -V80.2,V80.6 -V80.9, V81.2 -V81.9,V82.2 -V82.9,V87.9,V88.9,V89.1,V89.3,V89.9,V90 -V99
116	Falls	W00 -W19
117	Accidental discharge of firearms	W32 -W34
118	Accidental drowning and submersion	W65 -W74
119	Accidental suffocation and strangulation in bed	W75
120	Other accidental suffocation and strangulation	W76 -W77,W81 -W84
121	Accidental inhalation and ingestion of food or other objects causing obstruction of respiratory tract	W78 -W80
122	Accidents caused by exposure to smoke,fire and flames	X00 -X09
123	Accidental poisoning and exposure to noxious substances	X40 -X49
124	Other and unspecified accidents	W20 -W31,W35 -W64,W85 -W99,X10 -X39,X50 -X59
#	Assault (homicide	X85 -Y09,Y87.1
125	Assault (homicide)by hanging, strangulation and suffocation	X91
126	Assault (homicide)by discharge of firearms	X93 -X95
127	Neglect,abandonment and other maltreatment syndromes	Y06 -Y07

Table C. List of 130 Selected Causes of Infant Death (ICD-10)

128	Assault (homicide)by other and unspecified means	X85 -X90,X92,X96 -X99,Y00 -Y05,Y08 -Y09,Y87.1
129#	Complications of medical and surgical care	Y40 -Y84
130	Other external causes and their sequelae	X60 -X84,Y10 -Y36

Note: The causes listed with # in the number column are ranked to give the leading causes of death for certain population groups

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, US Department of Health and Human Services

Data Tables

Data Table 1. Population Growth Rate,
Davidson County/Nashville, TN, 1790-2000

Year	Population	Growth Rate	Year	Population	Growth Rate
1790	3,459	*	1900	122,815	13.5%
1800	9,965	188.1%	1910	149,478	21.7%
1810	15,608	56.6%	1920	167,815	12.3%
1820	20,154	29.1%	1930	222,854	32.8%
1830	28,122	39.5%	1940	257,264	15.4%
1840	30,509	8.5%	1950	321,758	25.1%
1850	38,882	27.4%	1960	399,743	24.2%
1860	47,055	21.0%	1970	448,003	12.1%
1870	62,897	33.7%	1980	477,811	6.7%
1880	79,026	25.6%	1990	510,784	6.9%
1890	108,174	36.9%	2000	569,891	11.6%

Source: 1. Forstall, RL. Population of States and Counties of the United States: 1790-1990,
U.S. Bureau of the Census. 2. 2000 Census

* Baseline

Data Table 2. Census Population by Public Health Planning District (PD),
Nashville, TN, 1990 and 2000

PD	1990	2000	% Change
1	5,131	5,026	-2.0
2	16,013	17,820	11.3
3	25,621	25,229	-1.5
4	37,835	41,229	9.0
5	65,751	64,840	-1.4
6	25,615	34,006	32.8
7a	12,977	12,791	-1.4
7b	27,812	26,991	-3.0
8	24,377	22,584	-7.4
9	3,183	3,401	6.8
10a	30,348	32,286	6.4
10b	36,354	42,182	16.0
11	31,607	33,775	6.9
12	63,327	77,441	22.3
13	44,304	57,579	30.0
14	60,529	72,711	20.1
Total	510,784	569,891	11.6

Source: U.S Census Bureau

Data Table 3. Census Population by Council District*,
Nashville, TN, 1990 and 2000

Council District	1990	2000	% Change
1	15,041	15,114	0.5
2	15,247	15,098	-1.0
3	14,767	15,410	4.4
4	15,158	16,790	10.8
5	14,441	13,839	-4.2
6	15,177	14,182	-6.6
7	15,302	14,911	-2.6
8	15,299	15,537	1.6
9	15,619	17,376	11.2
10	14,330	16,013	11.7
11	14,307	16,963	18.6
12	14,700	21,240	44.5
13	14,241	17,264	21.2
14	14,017	14,373	2.5
15	14,336	15,303	6.7
16	14,036	14,439	2.9
17	14,336	12,541	-12.5
18	13,936	14,646	5.1
19	13,911	13,650	-1.9
20	14,585	13,666	-6.3
21	14,051	15,122	7.6
22	14,339	14,822	3.4
23	15,017	17,716	18.0
24	15,320	15,059	-1.7
25	13,833	15,692	13.4
26	15,129	16,617	9.8
27	14,172	17,073	20.5
28	14,803	21,137	42.8
29	14,446	21,186	46.7
30	14,535	14,930	2.7
31	14,301	21,136	47.8
32	14,575	19,312	32.5
33	13,972	15,177	8.6
34	14,935	15,202	1.8
35	14,570	21,355	46.6
Total	510,784	569,891	11.6

Source: Metropolitan Planning Commission, 2002

* Metropolitan Council District (1991-2002)

Data Table 4. Population Changes by Age Group, Nashville, TN, 1990 and 2000

	1990	2000	% Change
Under 1	7,479	8,102	8.3
1-4	28,464	29,711	4.4
5-9	32,690	35,724	9.3
10-14	29,898	33,232	11.2
15-19	34,714	38,331	10.4
20-24	42,831	47,545	11.0
25-29	53,527	52,492	-1.9
30-34	50,513	47,695	-5.6
35-39	43,354	48,048	10.8
40-44	35,819	45,451	26.9
45-49	27,251	40,869	50.0
50-54	22,908	34,165	49.1
55-59	21,242	24,968	17.5
60-64	20,865	20,114	-3.6
65-69	19,022	17,282	-9.1
70-74	14,709	16,116	9.6
75-79	11,611	13,242	14.0
80-84	7,860	8,802	12.0
85+	6,027	8,002	32.8
Total	510,784	569,891	11.6

Data Table 5. 2000 Census Population by Age, Race, Gender, and Ethnicity, Nashville, TN
Table 5-1

	Black or African American			White			Other Races *			2000 Population Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
	68,658	79,038	147,696	184,790	196,993	381,783	22,417	17,995	40,412	275,865	294,026	569,891
Under 1 year	1,275	1,188	2,463	2,351	2,222	4,573	575	491	1,066	4,201	3,901	8,102
1-4 years	4,942	4,748	9,690	8,535	7,953	16,488	1,788	1,745	3,533	15,265	14,446	29,711
5 to 9 years	6,593	6,467	13,060	9,832	9,432	19,264	1,775	1,625	3,400	18,280	17,544	35,724
10 to 14 years	6,279	5,966	12,245	9,482	8,933	18,415	1,328	1,244	2,572	17,089	16,143	33,232
15 to 17 years	3,579	3,329	6,908	5,587	5,484	11,071	954	745	1,699	10,120	9,558	19,678
18 and 19 years	2,781	3,343	6,124	5,475	5,292	10,767	998	764	1,762	9,254	9,399	18,653
20 years	1,327	1,708	3,035	2,863	2,858	5,721	540	369	909	4,730	4,935	9,665
21 years	1,189	1,616	2,805	2,805	2,819	5,624	564	397	961	4,558	4,832	9,390
22 to 24 years	3,396	4,157	7,553	8,825	9,128	17,953	1,849	1,135	2,984	14,070	14,420	28,490
25 to 29 years	5,692	6,666	12,358	17,686	17,045	34,731	3,164	2,239	5,403	26,542	25,950	52,492
30 to 34 years	5,241	5,987	11,228	16,731	15,470	32,201	2,539	1,727	4,266	24,511	23,184	47,695
35 to 39 years	5,547	6,663	12,210	16,601	15,987	32,588	1,871	1,379	3,250	24,019	24,029	48,048
40 to 44 years	5,287	6,275	11,562	15,580	15,842	31,422	1,351	1,116	2,467	22,218	23,233	45,451
45 to 49 years	4,386	5,265	9,651	14,493	14,783	29,276	1,012	930	1,942	19,891	20,978	40,869
50 to 54 years	3,361	3,947	7,308	12,323	13,085	25,408	783	666	1,449	16,467	17,698	34,165
55 to 59 years	2,184	2,675	4,859	8,976	10,190	19,166	495	448	943	11,655	13,313	24,968
60 and 61 years	710	874	1,584	3,002	3,506	6,508	162	141	303	3,874	4,521	8,395
62 to 64 years	996	1,344	2,340	4,133	4,873	9,006	181	192	373	5,310	6,409	11,719
65 and 66 years	543	887	1,430	2,365	3,024	5,389	102	105	207	3,010	4,016	7,026
67 to 69 years	810	1,085	1,895	3,473	4,659	8,132	95	134	229	4,378	5,878	10,256
70 to 74 years	1,066	1,627	2,693	5,395	7,720	13,115	147	161	308	6,608	9,508	16,116
75 to 79 years	712	1,306	2,018	4,153	6,893	11,046	76	102	178	4,941	8,301	13,242
80 to 84 years	457	932	1,389	2,469	7,298	9,767	35	80	115	2,961	5,841	8,802
85 years and over	305	983	1,288	1,655	4,966	6,621	33	60	93	1,993	6,009	8,002
Total	68,658	79,038	147,696	184,790	196,993	381,783	22,417	17,995	40,412	275,865	294,026	569,891

Source: US Census Bureau Website, accessed on 10-15-2001

Data Table 5. 2000 Census Population by Age, Race, Gender, and Ethnicity, Nashville, TN
Table 5-2

Hispanic Alone			
Male	Female	total	Total:
15,933	10,158	26,091	
398	339	737	Under 1 year
1,197	1,055	2,252	1-4
969	982	1,951	5 to 9 years
773	629	1,402	10 to 14 years
686	381	1,067	15 to 17 years
858	502	1,360	18 and 19 years
509	276	785	20 years
525	259	784	21 years
1,810	842	2,652	22 to 24 years
2,663	1,401	4,064	25 to 29 years
1,938	1,059	2,997	30 to 34 years
1,349	752	2,101	35 to 39 years
819	567	1,386	40 to 44 years
571	378	949	45 to 49 years
383	260	643	50 to 54 years
197	161	358	55 to 59 years
58	34	92	60 and 61 years
66	68	134	62 to 64 years
28	25	53	65 and 66 years
35	43	78	67 to 69 years
51	55	106	70 to 74 years
25	42	67	75 to 79 years
15	23	38	80 to 84 years
10	25	35	85 years and over
15,933	10,158	26,091	Total:

Data Table 5. 2000 Census Population by Age, Race, Gender, and Ethnicity, Nashville, TN
Table 5-3

* Other Races in Detail																	
American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Some Other Race			Two or More Races			Other Races Total		
Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
914	765	1,679	6,693	6,582	13,275	202	201	403	8,674	5,142	13,816	5,934	5,305	11,239	22,417	17,995	40,412
9	9	18	121	113	234	5	6	11	215	179	394	225	184	409	575	491	1,066
51	40	91	409	421	830	19	18	37	633	601	1,234	676	665	1,341	1,788	1,745	3,533
40	42	82	487	410	897	17	11	28	541	564	1,105	690	598	1,288	1,775	1,625	3,400
42	34	76	388	394	782	9	19	28	381	333	714	508	464	972	1,328	1,244	2,572
33	24	57	263	261	524	6	8	14	380	211	591	272	241	513	954	745	1,699
33	26	59	247	272	519	10	10	20	474	263	737	234	193	427	998	764	1,762
21	19	40	115	114	229	5	3	8	284	138	422	115	95	210	540	369	909
16	11	27	123	132	255	7	4	11	297	139	436	121	111	232	564	397	961
49	37	86	404	374	778	14	22	36	1,071	437	1,508	311	265	576	1,849	1,135	2,984
88	87	175	916	880	1,796	28	26	54	1,514	741	2,255	618	505	1,123	3,164	2,239	5,403
94	75	169	794	724	1,518	26	16	42	1,107	495	1,602	518	417	935	2,539	1,727	4,266
107	62	169	623	601	1,224	18	15	33	707	338	1,045	416	363	779	1,871	1,379	3,250
84	66	150	470	470	940	12	11	23	429	270	699	356	299	655	1,351	1,116	2,467
73	83	156	363	411	774	8	7	15	289	166	455	279	263	542	1,012	930	1,942
69	42	111	328	331	659	10	3	13	174	115	289	202	175	377	783	666	1,449
44	41	85	242	229	471	2	2	4	75	49	124	132	127	259	495	448	943
13	11	24	85	73	158	1	2	3	23	13	36	40	42	82	162	141	303
13	16	29	96	102	198	0	4	4	19	27	46	53	43	96	181	192	373
7	11	18	58	55	113	0	2	2	7	10	17	30	27	57	102	105	207
5	4	9	46	72	118	0	1	1	15	12	27	29	45	74	95	134	229
9	6	15	62	69	131	3	6	9	20	20	40	53	60	113	147	161	308
11	6	17	28	34	62	1	2	3	11	6	17	25	54	79	76	102	178
2	8	10	12	26	38	0	1	1	5	9	14	16	36	52	35	80	115
1	5	6	13	14	27	1	2	3	3	6	9	15	33	48	33	60	93
914	765	1,679	6,693	6,582	13,275	202	201	403	8,674	5,142	13,816	5,934	5,305	11,239	22,417	17,995	40,412

Data Table 5. 2000 Census Population by Age, Race, Gender, and Ethnicity, Nashville, TN
Table 5-4

	All Races	White	Black	Other
15-44 years	139,540	89,925	39,744	9,871
10-19 years	35,100	19,709	12,638	2,753
10-17 years	25,701	14,417	9,295	1,989

Data Table 6. Population by Race, Ethnicity, Gender, and Public Health Planning District, Nashville, TN, 2000
2000 Census Data, Table 6-1

Health PD	2000 Population Total			Black or African American			White			Other Races*			Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
1	2,523	2,503	5,026	85	84	169	2,396	2,383	4,779	42	36	78	1
2	8,417	9,403	17,820	3,733	4,573	8,306	4,436	4,616	9,051	248	215	463	2
3	11,395	13,833	25,229	8,153	10,129	18,282	2,940	3,403	6,344	302	301	603	3
4	19,476	21,753	41,229	3,281	4,023	7,304	14,727	16,550	31,277	1,468	1,180	2,648	4
5	30,978	33,862	64,840	13,059	15,902	28,961	15,971	16,396	32,366	1,948	1,565	3,513	5
6	15,982	18,024	34,006	829	906	1,735	14,136	16,068	30,204	1,018	1,050	2,067	6
7a	7,658	5,134	12,791	2,001	862	2,862	5,040	3,955	8,995	617	317	934	7a
7b	13,067	13,924	26,991	917	964	1,881	11,109	12,081	23,190	1,041	879	1,920	7b
8	9,805	12,779	22,584	9,111	11,817	20,928	443	678	1,121	252	284	536	8
9	2,607	794	3,401	1,132	296	1,429	1,347	456	1,803	128	41	169	9
10a	15,503	16,782	32,286	4,663	5,978	10,641	9,503	9,631	19,134	1,338	1,173	2,511	10a
10b	19,258	22,924	42,182	389	506	895	18,233	21,797	40,030	636	621	1,257	10b
11	16,997	16,778	33,775	3,985	4,666	8,651	9,933	10,144	20,077	3,079	1,968	5,047	11
12	37,869	39,573	77,441	6,394	7,082	13,477	26,631	28,517	55,149	4,843	3,973	8,816	12
13	29,086	28,493	57,579	7,481	7,554	15,036	18,502	18,342	36,844	3,103	2,596	5,699	13
14	35,243	37,468	72,711	3,445	3,696	7,141	29,444	31,975	61,419	2,354	1,797	4,151	14

Data Table 6. Population by Race, Ethnicity, Gender, and Public Health Planning District, Nashville, TN, 2000
2000 Census Data, Table 6-2

Health PD	* Other Races in Detail														
	American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races			Some Other Race		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1	11	3	13	3	11	13	1	0	1	19	16	35	9	6	15
2	23	20	43	43	57	100	8	1	9	102	93	194	72	44	116
3	28	34	61	46	47	94	4	5	9	154	166	320	70	49	119
4	84	67	151	195	251	446	13	12	25	393	382	775	783	468	1,251
5	140	106	246	326	301	627	21	38	59	712	662	1,374	749	457	1,207
6	44	37	81	605	635	1,240	5	7	12	254	249	503	111	121	232
7a	47	27	74	105	87	192	4	2	6	133	81	215	328	120	448
7b	22	23	45	598	505	1,102	3	9	12	266	251	517	152	91	243
8	25	26	51	39	45	84	10	11	21	122	163	285	56	39	95
9	14	2	15	40	23	64	2	1	3	43	8	52	29	7	35
10a	39	22	60	835	789	1,623	18	12	30	307	248	555	140	103	242
10b	39	33	72	351	339	690	12	11	23	171	177	348	64	61	125
11	51	51	102	636	562	1,197	37	31	68	672	496	1,168	1,684	827	2,511
12	95	90	185	1,373	1,341	2,715	24	26	50	1,279	1,173	2,453	2,071	1,342	3,413
13	100	87	187	1,023	1,051	2,074	27	24	51	743	648	1,391	1,209	786	1,995
14	153	138	291	476	537	1,013	13	10	23	563	491	1,054	1,148	621	1,768

Data Table 6. Population by Race, Ethnicity, Gender, and Public Health Planning District, Nashville, TN, 2000
2000 Census Data, Table 6-3

Health PD	Hispanic Alone			Non-Hispanic White			Non-Hispanic Black			Non-Hispanic Other			Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
1	23	14	38	2,382	2,375	4,758	84	83	167	33	31	64	1
2	141	86	228	4,368	4,579	8,947	3,729	4,566	8,295	178	172	351	2
3	125	100	225	2,909	3,381	6,290	8,128	10,098	18,227	233	254	486	3
4	1,333	806	2,139	14,277	16,253	30,530	3,253	4,010	7,263	613	684	1,297	4
5	1,295	794	2,088	15,507	16,107	31,613	13,007	15,834	28,841	1,170	1,128	2,298	5
6	313	336	649	13,938	15,870	29,808	825	900	1,725	905	919	1,824	6
7a	579	265	844	4,818	3,823	8,642	1,996	859	2,854	265	186	451	7a
7b	354	257	611	10,921	11,924	22,845	911	958	1,869	880	785	1,666	7b
8	98	94	192	425	665	1,090	9,084	11,770	20,854	198	250	448	8
9	125	18	142	1,272	447	1,719	1,119	294	1,413	92	34	126	9
10a	407	331	738	9,265	9,430	18,695	4,642	5,958	10,600	1,189	1,063	2,253	10a
10b	233	227	460	18,084	21,638	39,721	387	501	888	555	557	1,112	10b
11	2,831	1,453	4,284	8,940	9,611	18,551	3,945	4,630	8,575	1,280	1,085	2,365	11
12	3,708	2,512	6,221	25,206	27,480	52,687	6,334	7,045	13,380	2,620	2,535	5,154	12
13	2,369	1,650	4,019	17,505	17,580	35,085	7,420	7,502	14,922	1,793	1,761	3,553	13
14	1,998	1,215	3,213	28,721	31,448	60,169	3,397	3,670	7,066	1,127	1,135	2,262	14

* Please be advised that the numbers in the health planning district tables are estimates based on the geographic overlap of health planning areas with census tracts. Only cell-specific estimates from these tables should be used, the total numbers from these estimates may be off by several individuals due to rounding errors and should not be used.

Data Table 7. Population by Age, Gender, and Public Health Planning District, Nashville, TN, 2000
2000 Census Data, Table 7-1

Health PD	Male																								Health PD
	<1	1-4	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+	
1	30	120	146	164	101	56	22	31	56	136	147	196	235	231	225	166	68	90	37	71	100	55	29	13	1
2	122	514	695	694	359	296	97	136	352	533	546	629	642	626	604	429	157	185	102	170	246	143	91	51	2
3	141	623	918	922	699	363	157	135	431	648	651	709	812	799	823	631	238	334	181	302	355	243	163	117	3
4	273	1,136	1,268	1,250	735	769	337	305	965	1,773	1,529	1,630	1,484	1,308	1,096	842	296	438	260	346	516	453	265	202	4
5	533	2,087	2,690	2,520	1,387	1,103	447	402	1,111	2,011	2,388	2,697	2,561	2,299	1,811	1,220	438	556	325	514	764	584	321	210	5
6	271	922	1,066	966	529	300	138	152	676	1,501	1,451	1,483	1,373	1,296	1,094	785	232	361	168	294	366	276	179	104	6
7a	89	273	340	272	191	188	153	145	505	978	951	912	757	615	396	262	89	106	66	81	122	83	60	26	7a
7b	210	764	828	833	440	271	114	157	522	1,081	1,017	991	1,084	1,003	854	705	204	310	185	284	503	391	225	91	7b
8	180	596	869	821	459	857	359	269	534	577	493	563	634	566	415	340	111	175	125	176	257	207	130	93	8
9	8	20	24	25	42	87	52	62	199	422	377	385	331	196	164	88	22	23	10	22	23	10	10	4	9
10a	178	523	686	690	435	1,389	846	708	1,249	1,808	1,363	1,151	995	972	712	448	128	214	109	156	262	225	133	123	10a
10b	178	737	955	1,038	666	537	279	283	802	1,324	1,364	1,299	1,553	1,663	1,638	1,103	353	473	280	429	686	625	438	355	10b
11	287	1,014	1,080	913	612	592	341	365	1,173	1,890	1,512	1,472	1,361	1,103	875	579	225	283	168	219	385	279	161	108	11
12	635	2,197	2,408	2,254	1,318	959	536	539	2,249	4,478	3,907	3,442	2,936	2,684	2,130	1,487	454	593	401	508	765	544	285	160	12
13	518	1,748	1,901	1,665	935	685	456	481	1,716	3,649	3,365	3,010	2,455	1,939	1,536	1,067	314	439	214	233	361	204	128	68	13
14	547	1,992	2,326	2,062	1,214	801	397	389	1,528	3,534	3,450	3,452	3,006	2,591	2,094	1,503	546	728	380	573	897	619	345	267	14

Data Table 7. Population by Age, Gender, and Public Health Planning District, Nashville, TN, 2000
2000 Census Data, Table 7-2

Health PD	Female																								Health PD
	<1	1-4	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+	
1	22	118	141	145	92	40	22	25	61	128	143	207	258	224	197	154	58	78	45	76	104	80	50	34	1
2	118	519	628	617	411	226	110	131	386	617	695	748	787	797	629	470	183	240	139	226	291	204	134	99	2
3	139	598	831	906	591	311	160	169	497	821	823	1,057	1,052	1,084	1,005	801	270	398	257	350	517	427	292	474	3
4	301	1,069	1,315	1,127	651	530	309	247	941	1,752	1,524	1,676	1,626	1,482	1,284	1,096	441	559	339	529	874	844	593	644	4
5	488	1,983	2,609	2,335	1,325	951	453	466	1,303	2,331	2,490	2,826	2,801	2,417	1,841	1,485	482	736	506	668	1,171	953	672	572	5
6	254	903	1,027	985	572	268	153	177	776	1,608	1,571	1,602	1,652	1,453	1,268	883	318	390	236	341	554	468	317	249	6
7a	68	259	328	248	157	107	48	60	240	542	491	460	430	375	284	214	77	105	80	96	149	142	99	74	7a
7b	174	645	743	770	441	230	137	171	550	1,021	949	1,104	1,169	1,083	954	729	240	356	253	385	675	549	353	243	7b
8	167	616	803	775	412	1,384	689	530	684	723	696	766	791	623	505	411	142	233	196	273	442	374	281	265	8
9	3	15	17	21	16	12	16	11	74	128	100	67	66	56	53	34	7	24	11	14	14	21	7	7	9
10a	154	525	707	604	388	1,834	963	856	1,260	1,719	1,252	993	987	865	728	479	160	251	183	239	436	430	340	429	10a
10b	184	718	1,004	1,062	677	650	306	324	982	1,721	1,452	1,520	1,789	1,934	1,729	1,266	408	568	346	503	934	1,031	832	983	10b
11	261	896	956	883	564	603	323	321	963	1,560	1,256	1,309	1,180	1,042	837	658	200	354	206	372	649	560	418	405	11
12	594	2,083	2,291	2,084	1,257	904	509	561	2,414	4,447	3,508	3,447	3,165	2,884	2,368	1,677	577	798	444	715	1,065	781	509	492	12
13	455	1,595	1,824	1,588	884	642	370	407	1,759	3,398	2,930	2,762	2,386	2,022	1,656	1,137	333	470	249	344	489	397	218	178	13
14	521	1,904	2,300	1,995	1,120	708	367	375	1,531	3,434	3,303	3,484	3,093	2,636	2,360	1,820	625	849	526	747	1,144	1,041	725	860	14

Data Table 7. Population by Age, Gender, and Public Health Planning District, Nashville, TN, 2000
2000 Census Data, Table 7-3

Health PD	Total																								Health PD
	<1	1-4	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+	
1	52	238	287	309	193	96	44	56	117	264	290	403	493	455	422	320	126	168	82	147	204	135	79	47	1
2	240	1,033	1,323	1,311	770	522	207	267	738	1,150	1,241	1,377	1,429	1,423	1,233	899	340	425	241	396	537	347	225	150	2
3	280	1,221	1,749	1,828	1,290	674	317	304	928	1,469	1,474	1,766	1,864	1,883	1,828	1,432	508	732	438	652	872	670	455	591	3
4	574	2,205	2,583	2,377	1,386	1,299	646	552	1,906	3,525	3,053	3,306	3,110	2,790	2,380	1,938	737	997	599	875	1,390	1,297	858	846	4
5	1,021	4,070	5,299	4,855	2,712	2,054	900	868	2,414	4,342	4,878	5,523	5,362	4,716	3,652	2,705	920	1,292	831	1,182	1,935	1,537	993	782	5
6	525	1,825	2,093	1,951	1,101	568	291	329	1,452	3,109	3,022	3,085	3,025	2,749	2,362	1,668	550	751	404	635	920	744	496	353	6
7a	157	532	668	520	348	295	201	205	745	1,520	1,442	1,372	1,187	990	680	476	166	211	146	177	271	225	159	100	7a
7b	384	1,409	1,571	1,603	881	501	251	328	1,072	2,102	1,966	2,095	2,253	2,086	1,808	1,434	444	666	438	669	1,178	940	578	334	7b
8	347	1,212	1,672	1,596	871	2,241	1,048	799	1,218	1,300	1,189	1,329	1,425	1,189	920	751	253	408	321	449	699	581	411	358	8
9	11	35	41	46	58	99	68	73	273	550	477	452	397	252	217	122	29	47	21	36	37	31	17	11	9
10a	332	1,048	1,393	1,294	823	3,223	1,809	1,564	2,509	3,527	2,615	2,144	1,982	1,837	1,440	927	288	465	292	395	698	655	473	552	10a
10b	362	1,455	1,959	2,100	1,343	1,187	585	607	1,784	3,245	2,816	2,819	3,342	3,597	3,367	2,369	761	1,041	626	932	1,620	1,656	1,270	1,338	10b
11	548	1,910	2,036	1,796	1,176	1,195	664	686	2,136	3,450	2,768	2,781	2,541	2,145	1,712	1,237	425	637	374	591	1,034	839	579	513	11
12	1,229	4,280	4,699	4,338	2,575	1,863	1,045	1,100	4,663	8,925	7,415	6,889	6,101	5,568	4,498	3,164	1,031	1,391	845	1,223	1,830	1,325	794	652	12
13	973	3,343	3,725	3,253	1,819	1,327	826	888	3,475	7,047	6,295	5,772	4,841	3,961	3,192	2,204	647	909	463	577	850	601	346	246	13
14	1,068	3,896	4,626	4,057	2,334	1,509	764	764	3,059	6,968	6,753	6,936	6,099	5,227	4,454	3,323	1,171	1,577	906	1,320	2,041	1,660	1,070	1,127	14

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-1-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1	<1	30	22	52	2	1	3	27	21	48	1	1	2
* 1-4	120	118	238	5	4	9	110	112	222	5	1	6	
* 5-9	146	141	287	8	7	15	136	132	268	2	2	4	
* 10-14	164	145	309	13	10	23	151	133	284	1	2	3	
* 15-17	101	92	193	2	4	6	97	86	183	2	2	4	
* 18-19	56	40	96	1	0	1	52	40	92	3	0	3	
* 20	22	22	44	1	1	2	22	22	44	0	0	0	
* 21	31	25	56	2	0	2	28	25	53	1	0	1	
* 22-24	56	61	117	2	0	2	53	59	112	1	2	3	
* 25-29	136	128	264	2	7	9	131	118	249	3	3	6	
* 30-34	147	143	290	4	5	9	142	136	278	2	2	4	
* 35-39	196	207	403	6	8	14	188	195	384	2	3	5	
* 40-44	235	258	493	10	12	22	223	243	466	3	3	6	
* 45-49	231	224	455	8	10	18	219	206	425	4	8	12	
* 50-54	225	197	422	9	6	15	214	185	399	3	5	8	
* 55-59	168	154	322	4	2	6	160	153	313	2	0	2	
* 60-64	68	58	126	3	0	3	64	57	121	2	1	3	
* 62-64	90	78	168	0	2	2	88	76	164	2	0	2	
* 65-66	37	45	82	0	1	1	37	44	81	0	0	0	
* 67-69	71	76	147	2	1	3	67	75	142	2	0	2	
* 70-74	100	104	204	2	1	3	94	101	195	4	3	7	
* 75-79	55	80	135	0	0	0	54	80	134	1	0	1	
* 80-84	29	50	79	1	1	2	28	49	77	0	0	0	
* 85+	13	34	47	0	0	0	13	34	47	0	0	0	

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-1-2

Health PD	* Other Races in Detail															Age Group	
	American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races			Some Other Race				
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
1	0	0	0	1	0	1	0	0	0	0	0	0	0	1	1	2	1-4
* 1	0	1	1	0	0	0	0	0	0	4	0	4	1	1	2	2	5-9
* 0	0	0	0	0	0	0	0	0	0	0	2	2	1	0	0	1	10-14
* 0	1	1	2	0	1	1	1	0	1	1	0	1	0	0	0	0	15-17
* 1	0	1	1	0	0	0	0	0	0	0	0	0	2	0	2	1	18-19
* 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20
* 0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	21
* 0	0	0	0	1	1	2	0	0	1	0	1	0	0	1	1	2	22-24
* 2	2	4	6	0	0	0	0	0	0	0	1	1	1	0	0	1	25-29
* 0	0	0	0	1	1	2	0	0	0	1	1	1	0	0	1	1	30-34
* 0	0	0	0	1	1	2	0	0	0	1	1	2	1	2	1	3	35-39
* 1	0	1	1	1	2	3	0	0	0	1	1	2	0	0	0	0	40-44
* 2	0	2	2	0	2	2	0	0	0	1	5	6	1	1	2	2	45-49
* 2	0	2	2	0	3	3	0	0	0	1	2	3	0	0	1	1	50-54
* 0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	0	0	55-59
* 0	0	0	0	0	0	0	0	0	0	2	1	3	0	0	0	0	60-64
* 0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	0	0	65-69
* 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70-74
* 0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	0	0	75-79
* 1	0	1	1	0	0	0	0	0	0	3	2	5	0	1	1	1	80-84
* 1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	85+
* 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	85+

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-1-3

Health PD	Hispanic Alone			Non-Hispanic White			Non-Hispanic Black			Non-Hispanic Other			Age Group	Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
1	0	1	1	27	21	48	2	1	4	1	0	2	<1	1
* 2	0	2	2	109	112	221	5	4	10	4	1	8	1-4	*
* 0	1	1	2	136	131	267	8	7	16	2	2	4	5-9	*
* 2	0	2	2	150	133	283	13	10	26	0	2	0	10-14	*
* 0	0	0	0	97	86	183	2	4	4	2	2	4	15-17	*
* 2	0	2	2	52	40	92	1	0	2	1	0	2	18-19	*
* 0	0	0	0	22	22	44	1	1	2	0	0	0	20	*
* 1	0	1	1	28	25	53	2	0	4	0	0	0	21	*
* 1	1	2	3	32	29	61	2	0	4	1	1	2	22-24	*
* 3	2	5	7	129	117	246	2	7	4	2	2	4	25-29	*
* 2	0	2	2	141	136	277	4	5	8	1	2	2	30-34	*
* 4	3	7	10	186	194	380	6	8	12	0	2	0	35-39	*
* 4	2	6	8	218	242	460	10	11	20	3	3	6	40-44	*
* 3	3	6	9	218	205	423	7	10	14	3	6	6	45-49	*
* 0	1	1	2	214	184	398	9	6	18	3	5	8	50-54	*
* 1	0	1	1	150	153	312	4	2	8	2	0	4	55-59	*
* 0	0	0	0	64	57	121	3	0	6	2	1	4	60-61	*
* 0	0	0	0	88	76	164	0	2	0	2	0	4	62-64	*
* 0	0	0	0	37	44	81	0	1	0	0	0	0	65-66	*
* 0	0	0	0	67	75	142	2	1	4	2	0	4	67-69	*
* 0	1	1	2	94	100	194	2	1	4	4	3	8	70-74	*
* 0	0	0	0	54	80	134	0	0	0	1	0	2	75-79	*
* 0	1	1	2	28	48	76	1	1	2	0	0	0	80-84	*
* 0	0	0	0	13	34	47	0	0	0	0	0	0	85+	*

* Please be advised that the numbers in the health PD tables are estimates based on the geographic overlap of health PD with census tracts. Only cell-specific estimates from these tables should be used, the total population for these estimates may be off by several individuals due to rounding errors and should not be used.

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-2-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
2	<1	122	118	240	72	73	145	43	42	85	7	3	10
* 1-4	514	519	1,033	307	288	595	190	202	392	17	29	46	
* 5-9	695	628	1,323	439	406	845	234	207	441	22	15	37	
* 10-14	991	617	1,608	428	300	728	240	246	486	25	11	36	
* 15-17	359	411	770	221	233	454	133	164	297	4	13	17	
* 18-19	296	226	522	134	131	265	154	87	241	8	8	16	
* 20	97	110	207	45	70	115	49	34	83	3	6	9	
* 21	136	131	267	73	67	140	56	57	113	7	7	14	
* 22-24	352	386	738	172	242	414	164	132	296	16	12	28	
* 25-29	533	617	1,150	255	377	632	253	229	482	26	10	36	
* 30-34	546	695	1,241	254	386	640	277	285	562	15	14	29	
* 35-39	629	748	1,377	282	404	686	348	327	675	19	16	35	
* 40-44	642	787	1,429	261	402	663	361	375	736	19	9	28	
* 45-49	626	797	1,423	247	367	614	362	413	775	17	18	35	
* 50-54	604	629	1,233	235	295	530	355	321	676	14	14	28	
* 55-59	429	470	899	130	161	291	289	302	591	10	6	16	
* 60-61	157	183	340	39	51	90	115	127	242	2	5	7	
* 62-64	183	240	423	44	75	119	136	161	297	5	4	9	
* 65-66	102	139	241	20	30	50	80	106	186	2	3	5	
* 67-69	170	226	396	25	48	73	144	175	319	1	3	4	
* 70-74	246	291	537	40	46	86	201	241	442	6	4	10	
* 75-79	143	204	347	15	33	48	125	169	294	2	2	4	
* 80-84	91	134	225	7	14	21	83	118	201	0	2	2	
* 85+	51	99	150	5	13	18	45	86	131	1	0	1	

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-2-2

Health PD	* Other Races in Detail															Age Group
	American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races			Some Other Race			
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
2	0	0	0	1	0	1	0	0	0	6	1	7	0	2	2	<1
* 2	0	0	2	3	1	11	0	0	10	23	6	3	1	3	1	1.4
* *	1	1	2	3	1	4	0	0	13	10	23	5	3	8	5	5.9
* *	1	0	1	4	3	7	0	0	14	7	21	6	1	7	10	14
* *	0	0	0	1	6	7	0	0	1	3	4	2	4	6	15	17
* *	1	1	2	5	1	4	0	0	1	3	4	3	3	6	18	19
* *	1	1	2	0	0	0	1	0	3	1	7	1	0	1	2	20
* *	0	0	0	1	3	4	1	0	1	1	2	4	3	7	21	
* *	0	3	3	2	3	5	1	1	2	5	4	9	8	1	9	22.24
* *	1	2	3	2	1	3	4	0	4	11	2	13	7	5	12	25.29
* *	1	0	1	2	2	4	2	0	2	5	7	10	7	5	12	30.34
* *	1	8	9	10	0	0	0	0	6	11	6	8	4	5	33	39
* *	3	1	4	4	4	8	0	0	4	2	6	8	2	10	40	44.44
* *	3	4	7	7	4	11	0	0	4	6	10	3	4	7	45	49.40
* *	0	0	0	5	5	5	0	0	12	5	17	2	4	6	50	54.40
* *	0	0	0	5	2	7	0	0	0	3	3	6	2	1	3	55.59
* *	0	2	2	1	1	0	0	0	2	2	4	0	0	0	60	61.40
* *	2	1	3	3	1	4	2	0	0	2	2	4	0	0	62	64.44
* *	0	1	1	0	1	1	0	0	0	1	2	1	0	0	1	65.66
* *	0	1	1	1	0	1	0	0	0	1	1	1	0	1	1	67.69
* *	1	1	2	1	1	2	0	0	4	2	6	0	0	0	70	74.74
* *	0	0	0	1	1	0	0	0	0	1	2	1	0	1	75	79.79
* *	0	0	0	0	1	1	0	0	0	1	1	0	0	0	80	84.84
* *	0	0	0	1	0	1	0	0	0	0	0	0	0	0	85	89.89

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-3-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
3	<1	141	139	280	109	106	215	21	30	51	12	2	14
* 1-4	1-4	623	598	1,221	476	468	944	119	106	225	28	25	53
* 5-9	5-9	918	821	1,739	708	665	1,373	171	140	311	39	26	65
* 10-14	10-14	922	906	1,828	740	726	1,466	159	158	317	23	22	45
* 15-17	15-17	699	591	1,290	530	459	989	152	110	262	16	22	38
* 18-19	18-19	363	311	674	275	248	523	79	56	135	8	7	15
* 20	20	157	160	317	119	135	254	33	23	56	5	2	7
* 21	21	135	169	304	111	125	236	21	38	59	3	6	9
* 22-24	22-24	431	497	928	301	374	675	103	103	206	27	19	46
* 25-29	25-29	648	821	1,469	460	587	1,047	159	208	367	29	27	56
* 30-34	30-34	651	823	1,474	449	572	1,021	186	231	417	16	20	36
* 35-39	35-39	709	1,057	1,766	482	765	1,247	205	268	473	22	24	46
* 40-44	40-44	812	1,052	1,864	547	749	1,296	252	280	532	13	23	36
* 45-49	45-49	799	1,084	1,883	538	798	1,336	242	265	507	19	22	41
* 50-54	50-54	823	1,005	1,828	570	755	1,325	243	237	480	11	13	24
* 55-59	55-59	631	801	1,432	446	609	1,055	176	176	352	9	17	26
* 60-61	60-61	238	270	508	170	201	371	62	66	128	5	3	8
* 62-64	62-64	334	398	732	239	305	544	93	89	182	2	5	7
* 65-66	65-66	181	257	438	126	186	312	51	67	118	4	5	9
* 67-69	67-69	302	350	652	207	241	448	94	108	202	1	1	2
* 70-74	70-74	355	517	872	224	333	557	129	178	307	2	6	8
* 75-79	75-79	243	427	670	154	261	415	87	162	249	2	5	7
* 80-84	80-84	163	292	455	100	176	276	59	116	175	4	1	5
* 85+	85+	117	474	591	74	286	360	42	187	229	1	1	2

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-3-2

Health PD	* Other Races in Detail												Age Group
	American Indian/Alaska Native			Asian			Hawaiian/Pacific Islander			Two or More Races			Age Group
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
3	0	0	0	1	0	1	0	0	0	9	1	10	<1
* 1-4	3	1	4	0	1	1	0	1	1	15	14	29	1-4
* 5-9	2	1	3	3	0	3	0	1	1	27	17	44	5-9
* 10-14	1	2	3	1	3	4	0	0	0	17	13	30	10-14
* 15-17	0	3	3	3	1	4	0	0	0	12	15	27	15-17
* 18-19	2	1	3	1	2	3	0	0	0	3	3	6	18-19
* 20	0	0	0	0	0	0	0	0	0	4	2	6	20
* 21	0	2	2	2	1	3	0	0	0	1	3	4	21
* 22-24	0	2	2	5	2	7	0	1	1	9	8	17	22-24
* 25-29	1	2	3	10	5	15	1	2	3	6	13	19	25-29
* 30-34	2	3	5	4	2	6	0	0	0	5	11	16	30-34
* 35-39	2	2	4	0	4	4	1	0	1	11	15	26	35-39
* 40-44	3	3	6	3	5	8	0	1	1	6	13	19	40-44
* 45-49	5	5	10	4	8	12	0	0	0	9	9	18	45-49
* 50-54	1	1	2	2	4	6	0	0	0	11	14	25	50-54
* 55-59	1	5	6	2	4	6	1	0	1	3	8	11	55-59
* 60-61	0	1	1	3	0	3	0	0	0	2	1	3	60-61
* 62-64	1	0	1	0	2	2	0	0	0	1	2	3	62-64
* 65-66	1	0	1	1	1	2	0	0	0	2	3	5	65-66
* 67-69	1	0	1	0	0	0	0	0	0	1	1	0	67-69
* 70-74	0	0	0	1	1	2	0	0	0	1	5	6	70-74
* 75-79	1	0	1	0	0	0	0	0	0	1	5	6	75-79
* 80-84	0	0	0	0	0	0	0	0	0	3	0	3	80-84
* 85+	0	0	0	0	0	0	0	0	0	1	1	2	85+

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-3-3

Health PD	Hispanic Alone			Non-Hispanic White			Non-Hispanic Black			Non-Hispanic Other			Age Group	Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
3	8	9	17	108	104	212	108	104	212	10	1	11	<1	3
* 1-4	8	10	18	119	104	223	476	466	952	20	19	40	1-4	*
* 5-9	12	6	18	166	140	306	705	662	1,410	35	23	70	5-9	*
* 10-14	14	9	23	156	157	313	731	724	1,462	21	16	42	10-14	*
* 15-17	4	6	10	151	110	261	529	456	1,058	14	19	28	15-17	*
* 18-19	5	3	8	77	56	133	275	246	550	5	6	10	18-19	*
* 20	1	1	2	32	22	56	119	135	236	4	1	6	20	*
* 21	0	0	0	21	38	59	111	125	222	3	6	9	21	*
* 22-24	15	7	22	102	104	206	300	374	600	14	13	28	22-24	*
* 25-29	18	10	28	154	206	360	459	585	918	17	21	34	25-29	*
* 30-34	9	11	20	183	227	410	448	570	896	11	15	22	30-34	*
* 35-39	10	7	17	203	268	471	481	763	962	14	20	28	35-39	*
* 40-44	5	7	12	249	278	527	545	746	1,090	12	21	24	40-44	*
* 45-49	2	4	6	241	262	503	537	796	1,074	18	22	38	45-49	*
* 50-54	6	5	11	242	234	476	568	755	1,136	8	11	16	50-54	*
* 55-59	6	3	9	174	175	349	444	607	888	7	17	14	55-59	*
* 60-61	0	2	2	62	66	128	170	201	340	5	1	10	60-61	*
* 62-64	0	1	1	93	89	182	239	304	478	2	5	4	62-64	*
* 65-66	1	2	3	30	66	116	126	185	252	4	5	6	65-66	*
* 67-69	0	0	0	94	108	202	207	241	414	1	1	2	67-69	*
* 70-74	0	2	2	129	177	306	224	332	448	2	6	4	70-74	*
* 75-79	1	0	1	86	162	248	154	261	308	2	5	4	75-79	*
* 80-84	1	0	1	59	116	175	99	176	198	4	1	8	80-84	*
* 85+	1	0	1	41	167	228	74	286	148	1	1	2	85+	*

* Please be advised that the numbers in the health PD tables are estimates based on the geographic overlap of health PD with census tracts. Only cell-specific estimates from these tables should be used; the total numbers from these estimates may be off by several individuals due to rounding errors and should not be used.

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-4-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
4	<1	273	301	574	47	72	119	188	189	377	38	40	78
*	1-4	1,136	1,069	2,205	273	269	542	739	681	1,420	124	119	243
*	5-9	1,288	1,315	2,583	327	364	701	823	823	1,646	108	128	236
*	10-14	1,250	1,127	2,377	332	299	631	831	753	1,584	87	75	162
*	15-17	735	651	1,386	183	163	346	475	433	908	77	55	132
*	18-19	769	530	1,299	129	127	256	559	362	921	81	41	122
*	20	337	309	646	56	70	126	244	216	460	37	23	60
*	21	305	247	552	47	63	110	208	166	374	50	18	68
*	22-24	965	941	1,906	173	220	393	657	656	1,313	135	65	200
*	25-29	1,773	1,752	3,525	312	428	740	1,252	1,194	2,446	200	130	339
*	30-34	1,529	1,524	3,053	290	356	646	1,112	1,077	2,189	127	91	218
*	35-39	1,630	1,676	3,306	316	386	702	1,204	1,210	2,414	110	80	190
*	40-44	1,484	1,626	3,110	245	320	565	1,153	1,224	2,377	86	82	168
*	45-49	1,308	1,482	2,790	196	283	479	1,041	1,127	2,168	71	72	143
*	50-54	1,096	1,284	2,380	135	205	340	912	1,028	1,940	49	51	100
*	55-59	842	1,096	1,938	66	109	175	739	909	1,698	37	28	65
*	60-61	296	441	737	16	31	47	270	399	669	10	11	21
*	62-64	438	559	997	31	52	83	400	501	901	7	6	13
*	65-66	260	339	599	15	30	45	243	301	544	2	8	10
*	67-69	346	329	675	22	29	51	320	482	802	4	18	22
*	70-74	516	674	1,190	28	53	81	480	512	1,292	8	9	17
*	75-79	453	844	1,297	19	40	59	435	789	1,228	8	11	19
*	80-84	265	593	858	15	29	44	250	553	803	0	11	11
*	85- 202	644	846	1,490	7	25	32	192	611	803	3	8	11

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-5-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
5	<1	533	488	1,021	290	265	555	194	164	358	49	58	107
* 1-4	2,087	1,983	4,070	1,193	1,151	2,344	702	632	1,334	193	200	393	
* 5-9	2,600	2,609	5,299	1,555	1,591	3,146	921	832	1,753	214	187	401	
* 10-14	2,520	2,535	5,055	1,518	1,596	3,114	847	795	1,642	155	143	298	
* 15-17	1,387	1,325	2,712	822	799	1,621	427	449	876	91	77	170	
* 18-19	1,103	951	2,054	454	529	983	560	350	910	89	72	161	
* 20	447	453	900	168	246	414	231	185	416	48	22	70	
* 21	402	466	868	175	283	458	182	154	336	44	29	73	
* 22-24	1,111	1,303	2,414	467	704	1,171	525	532	1,057	119	67	186	
* 25-29	2,011	2,351	4,342	785	1,129	1,914	1,026	1,070	2,096	200	151	351	
* 30-34	2,358	2,490	4,878	840	1,145	1,988	1,366	1,248	2,614	178	97	275	
* 35-39	2,897	2,826	5,523	977	1,391	2,368	1,563	1,330	2,893	157	105	262	
* 40-44	2,561	2,801	5,362	972	1,341	2,313	1,458	1,357	2,815	131	103	234	
* 45-49	2,299	2,417	4,716	817	1,065	1,882	1,390	1,265	2,655	92	87	179	
* 50-54	1,811	1,841	3,652	624	767	1,391	1,114	1,026	2,140	73	48	121	
* 55-59	1,220	1,485	2,705	413	540	953	767	909	1,676	40	36	76	
* 60-64	438	482	920	146	181	327	282	370	9	13	22		
* 65-64	556	736	1,292	166	285	451	375	431	806	15	19	34	
* 65-66	325	506	831	102	177	279	219	321	540	5	8	13	
* 67-69	514	668	1,182	166	183	349	340	470	810	8	15	23	
* 70-74	764	1,171	1,935	199	277	476	548	876	1,424	17	17	34	
* 75-79	584	953	1,537	105	205	310	469	733	1,202	10	15	25	
* 80-84	321	672	993	64	139	203	251	530	781	5	3	8	
* 85+	210	572	782	37	113	150	169	450	619	3	10	13	

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-5-2

Health PD	* Other Races in Detail															Age Group
	American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races			Some Other Race			
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
5	1	2	3	2	8	10	2	3	5	30	28	58	14	17	31	1-4
* 9	7	16	24	19	43	6	7	13	87	105	192	66	62	128	5	1
* 6	7	13	39	19	58	3	4	7	105	77	182	60	80	140	5-9	5
* 5	2	7	39	33	72	0	3	3	72	67	139	39	38	77	10-14	10
* 8	1	9	24	19	43	1	0	1	26	39	65	33	18	51	15-17	15
* 10	6	16	10	22	32	1	2	3	27	19	46	40	23	63	18-19	20
* 3	4	7	5	4	9	0	0	0	15	6	21	25	33	58	20	25
* 2	0	2	3	7	10	2	1	3	10	12	22	27	9	36	21	30
* 4	3	7	12	9	21	0	9	9	33	20	53	70	26	96	22-24	35
* 8	8	14	25	27	62	0	5	5	60	42	102	99	49	148	25-29	40
* 10	8	18	28	18	46	0	1	1	40	39	79	100	51	151	30-34	45
* 20	10	30	21	24	45	1	1	2	45	40	85	70	30	100	35-39	50
* 13	12	25	17	23	40	1	0	1	50	46	96	50	22	72	40-44	55
* 16	17	33	21	18	39	3	1	4	29	35	64	23	16	39	45-49	60
* 10	4	14	16	16	32	1	0	1	30	18	48	16	10	26	50-54	65
* 5	6	11	12	12	24	0	0	0	18	14	32	5	4	9	55-59	70
* 2	2	4	3	4	8	0	0	0	4	14	18	0	2	2	60-61	75
* 1	3	4	5	3	8	0	0	0	7	8	15	2	5	7	62-64	80
* 1	1	2	2	3	5	0	0	0	2	3	5	0	1	1	65-66	85
* 1	0	1	0	7	7	0	0	0	5	7	12	2	1	3	67-69	90
* 3	0	3	4	5	9	0	1	1	5	9	14	5	2	7	70-74	95
* 2	3	5	2	2	4	0	0	0	5	8	13	1	2	3	75-79	100
* 0	0	0	1	0	1	0	0	0	3	3	6	1	0	1	80-84	105
* 0	0	0	0	0	0	0	0	0	3	9	12	0	1	1	85+	110

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-5-3

Health PD	Hispanic Alone			Non-Hispanic White			Non-Hispanic Black			Non-Hispanic Other			Age Group	Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
5	25	27	52	183	156	339	289	263	578	36	41	77	<1	5
*	95	99	194	668	596	1,264	1,189	1,145	2,378	136	143	272	1-4	*
*	96	117	213	890	797	1,687	1,547	1,579	3,024	157	117	314	5-9	*
*	74	58	132	815	776	1,591	1,511	1,391	3,092	120	109	240	10-14	*
*	54	18	72	452	444	896	821	798	1,642	60	65	120	15-17	*
*	78	37	115	528	344	872	452	522	904	44	48	88	18-19	*
*	40	12	52	219	181	400	168	245	336	20	15	40	20	*
*	43	21	64	169	142	311	173	281	346	16	22	32	21	*
*	116	53	169	486	512	998	466	698	932	43	40	86	22-24	*
*	178	78	256	963	1,043	2,006	780	1,127	1,560	90	82	180	25-29	*
*	163	75	238	1,312	1,209	2,521	840	1,139	1,680	72	67	144	30-34	*
*	122	63	185	1,518	1,306	2,824	972	1,383	1,944	85	74	170	35-39	*
*	85	53	138	1,434	1,334	2,768	964	1,337	1,928	78	77	156	40-44	*
*	45	26	71	1,374	1,258	2,632	815	1,062	1,630	65	71	130	45-49	*
*	37	17	54	1,100	1,021	2,121	622	765	1,244	52	38	104	50-54	*
*	14	11	25	738	903	1,661	413	540	826	35	31	70	55-59	*
*	6	3	9	276	287	563	146	181	292	9	11	18	60-61	*
*	7	8	15	370	428	798	166	284	332	13	15	26	62-64	*
*	0	1	1	219	321	540	102	177	204	5	7	10	65-66	*
*	3	2	5	339	469	808	166	183	332	6	14	12	67-69	*
*	9	7	16	546	872	1,418	199	277	398	10	14	20	70-74	*
*	2	5	7	469	730	1,199	104	205	208	9	13	18	75-79	*
*	1	0	1	251	530	781	64	139	128	4	3	8	80-84	*
*	1	2	3	168	449	617	37	113	74	3	9	6	85+	*

* Please be advised that the numbers in the health PD tables are estimates based on the geographic overlap of health PD with census tracts. Only cell-specific estimates from these tables should be used, the total numbers from these estimates may be off by several individuals due to rounding errors and should not be used.

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-6-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0	<1	271	254	525	11	14	25	239	209	448	21	30	51
* 1-4	922	903	1,825	43	47	90	797	759	1,556	81	97	178	
* 5-9	1,066	1,027	2,093	65	57	122	906	879	1,785	94	90	184	
* 10-14	966	988	1,951	73	50	123	802	833	1,635	91	82	173	
* 15-17	529	572	1,101	26	41	67	464	498	953	38	41	79	
* 18-19	300	268	568	16	22	38	268	228	496	16	17	33	
* 20	138	153	291	15	14	29	119	127	246	4	12	16	
* 21	152	177	329	25	23	48	123	149	272	4	4	8	
* 22-24	676	776	1,452	76	74	150	551	669	1,220	50	33	83	
* 25-29	1,501	1,608	3,109	110	120	230	1,284	1,363	2,647	106	126	232	
* 30-34	1,451	1,571	3,022	64	80	144	1,270	1,378	2,648	117	114	231	
* 35-39	1,483	1,602	3,085	75	74	149	1,305	1,428	2,733	103	100	203	
* 40-44	1,373	1,652	3,025	60	78	138	1,233	1,475	2,708	80	99	179	
* 45-49	1,296	1,453	2,749	48	64	112	1,184	1,333	2,517	64	56	120	
* 50-54	1,094	1,288	2,382	63	62	125	991	1,164	2,155	41	42	83	
* 55-59	785	883	1,668	26	33	59	732	816	1,548	27	33	60	
* 60-61	232	318	550	4	6	10	211	262	513	17	10	27	
* 62-64	361	390	751	10	9	19	331	361	692	20	20	40	
* 65-66	168	236	404	1	9	10	162	216	378	5	11	16	
* 67-69	294	341	635	3	5	8	274	324	598	16	11	27	
* 70-74	366	554	920	9	6	15	346	540	886	11	8	19	
* 75-79	278	468	744	4	13	17	267	448	715	5	12	17	
* 80-84	170	317	486	1	3	4	176	312	488	2	3	5	
* 85+	109	240	353	0	2	2	100	244	344	4	3	7	

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-7a-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
7a	<1	89	68	157	18	15	33	56	47	103	16	7	23
*	1-4	273	259	532	60	86	146	180	145	325	33	28	61
*	5-9	340	328	668	97	76	173	210	220	430	33	32	65
*	10-14	272	248	520	66	64	130	190	163	353	16	21	37
*	15-17	191	157	348	61	29	90	114	116	230	16	12	28
*	18-19	188	107	295	77	21	98	90	82	172	22	5	27
*	20	153	48	201	59	16	75	76	28	104	18	4	22
*	21	145	60	205	48	20	68	74	39	113	23	2	25
*	22-24	305	240	545	173	52	225	267	168	435	65	20	85
*	25-29	978	542	1,520	301	86	387	572	411	983	105	46	151
*	30-34	951	491	1,442	251	65	316	613	382	995	86	45	131
*	35-39	912	460	1,372	268	77	345	589	365	954	55	18	73
*	40-44	757	430	1,187	212	66	278	500	346	846	45	18	63
*	45-49	615	375	990	129	53	182	457	302	759	29	21	50
*	50-54	396	284	680	66	31	97	309	242	551	20	11	31
*	55-59	262	214	476	42	31	73	211	170	381	10	12	22
*	60-61	89	77	166	16	11	27	69	66	135	4	1	5
*	62-64	106	105	211	20	14	34	78	87	165	9	5	14
*	65-66	66	80	146	3	14	17	57	66	123	6	1	7
*	67-69	81	96	177	15	7	22	65	86	151	2	3	5
*	70-74	122	149	271	14	16	30	103	131	236	4	2	6
*	75-79	63	142	225	3	10	13	79	132	211	1	1	2
*	80-84	60	99	159	6	2	8	54	94	148	0	3	3
*	85+	26	74	100	0	2	2	26	71	97	0	1	1

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-7a-2

Health PD	American Indian/Alaska			Asian			* Other Races in Detail			Two or More Races			Some Other Race			Age Group
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
7a	0	0	0	4	2	6	0	0	0	3	5	8	9	0	9	<1
*	2	0	2	6	8	14	0	0	0	12	6	18	13	14	27	1-4
*	0	0	0	4	4	8	0	0	0	10	10	20	19	18	37	5-9
*	0	1	1	5	1	6	0	0	0	3	6	9	8	13	21	10-14
*	1	0	1	4	2	6	0	0	0	5	3	8	6	7	13	15-17
*	0	0	0	1	0	1	0	0	0	4	1	5	17	4	21	18-19
*	4	0	4	2	0	2	0	0	0	2	1	3	10	3	13	20
*	2	1	3	0	0	0	0	0	0	3	0	3	18	1	19	21
*	2	2	4	5	6	11	0	0	0	10	3	13	48	9	57	22-24
*	4	4	8	23	19	42	1	1	2	21	6	27	57	16	73	25-29
*	6	4	10	19	20	39	1	0	1	15	8	23	46	13	59	30-34
*	5	2	7	10	5	15	0	0	0	7	5	12	33	3	36	35-39
*	6	3	9	3	2	5	2	1	3	15	4	19	19	8	27	40-44
*	2	2	4	5	3	8	0	0	0	8	11	19	14	5	19	45-49
*	6	2	8	5	10	0	0	0	0	3	3	6	6	1	7	50-54
*	3	1	4	2	4	6	0	0	0	3	6	9	2	1	3	55-59
*	1	1	2	1	0	1	0	0	0	0	0	0	2	2	4	60-61
*	1	1	2	3	4	7	0	0	0	5	0	5	0	0	0	62-64
*	2	0	2	0	0	0	0	0	0	3	1	4	1	0	1	65-66
*	0	0	0	2	2	4	0	0	0	0	1	1	0	0	0	67-69
*	0	1	1	2	0	2	0	0	0	1	1	2	1	0	1	70-74
*	0	1	1	0	0	0	0	0	0	1	0	1	0	0	0	75-79
*	0	1	1	0	1	1	0	0	0	0	0	0	0	0	1	80-84
*	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	85+

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-7a-3

Health PD	Hispanic Alone			Non-Hispanic White			Non-Hispanic Black			Non-Hispanic Other			Age Group	Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
7a	14	23	31	41	91	134	15	13	28	14	23	37	<1	7a
*	25	27	52	170	133	303	60	86	120	18	13	36	1-4	*
*	30	35	65	198	206	404	97	76	194	15	11	30	5-9	*
*	16	20	36	182	156	338	66	64	132	8	8	16	10-14	*
*	12	11	23	109	112	221	61	29	122	9	5	18	15-17	*
*	35	9	44	75	76	151	76	21	152	3	2	6	18-19	*
*	23	4	29	65	25	90	59	16	116	6	1	12	20	*
*	30	5	33	63	37	100	48	20	96	4	1	8	21	*
*	84	26	110	236	153	389	171	51	342	14	10	28	22-24	*
*	99	38	137	536	392	928	300	84	600	43	29	86	25-29	*
*	85	26	111	583	369	952	250	65	500	33	32	66	30-34	*
*	55	19	74	568	352	920	268	77	536	21	12	42	35-39	*
*	39	15	54	483	341	824	212	66	424	23	8	46	40-44	*
*	21	10	31	450	298	748	129	53	258	15	15	30	45-49	*
*	7	3	10	307	240	547	66	31	132	15	10	30	50-54	*
*	1	3	4	211	168	379	42	31	84	9	11	18	55-59	*
*	2	0	2	68	66	134	16	11	32	3	1	6	60-61	*
*	0	3	3	78	84	162	20	14	40	9	5	18	62-64	*
*	1	2	3	57	65	122	3	14	6	5	1	10	65-66	*
*	0	0	0	65	86	151	15	7	30	2	3	4	67-69	*
*	1	0	1	105	131	236	14	16	28	3	2	6	70-74	*
*	0	0	0	79	132	211	3	10	6	1	1	2	75-79	*
*	0	2	2	54	93	147	6	2	12	0	2	0	80-84	*
*	0	0	0	26	71	97	0	2	0	0	1	0	85+	*

* Please be advised that the numbers in the health PD tables are estimates based on the geographic overlap of health PD with census tracts. Only cell-specific estimates from these tables should be used, the total numbers from these estimates may be off by several individuals due to rounding errors and should not be used.

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-7b-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
7b	<1	210	174	384	28	15	43	154	140	294	29	18	47
*	1-4	764	645	1,409	87	57	144	605	517	1,122	72	71	143
*	5-9	828	743	1,571	78	65	143	673	638	1,311	77	41	118
*	10-14	833	770	1,603	68	61	129	700	655	1,355	64	54	118
*	15-17	440	441	881	40	29	69	346	368	714	54	45	99
*	18-19	271	230	501	27	29	56	199	166	365	45	36	81
*	20	114	137	251	23	28	51	82	99	181	8	10	18
*	21	157	171	328	32	39	71	112	119	231	13	13	26
*	22-24	522	550	1,072	79	108	187	579	594	773	64	47	111
*	25-29	1,081	1,021	2,102	128	131	259	812	793	1,605	140	97	237
*	30-34	1,017	949	1,966	88	95	183	811	767	1,578	118	87	205
*	35-39	991	1,104	2,095	62	82	144	848	956	1,804	82	66	148
*	40-44	1,084	1,169	2,253	67	67	134	959	1,026	1,985	57	76	133
*	45-49	1,003	1,083	2,086	28	44	72	935	987	1,922	40	52	92
*	50-54	854	954	1,808	32	33	65	770	867	1,637	51	55	106
*	55-59	705	729	1,434	17	22	39	641	671	1,312	47	36	83
*	60-61	204	240	444	4	6	10	182	219	401	18	16	34
*	62-64	310	356	666	5	10	15	287	330	617	19	17	36
*	65-66	185	253	438	4	6	10	169	239	408	11	8	19
*	67-69	284	385	669	7	13	20	269	362	631	8	10	18
*	70-74	503	675	1,178	4	8	12	468	652	1,140	11	15	26
*	75-79	391	549	940	5	9	14	383	533	916	3	6	9
*	80-84	225	353	578	4	6	10	214	345	559	6	2	8
*	85+	91	243	334	0	4	4	89	237	326	2	2	4

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-7b-2

Health PD	American Indian/Alaska		
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Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-10a-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
10a	<1	178	154	332	83	78	161	73	59	132	22	17	39
*	1-4	523	525	1,048	290	316	606	174	143	319	59	64	123
*	5-9	686	707	1,393	424	423	847	196	218	408	72	67	139
*	10-14	690	604	1,294	419	388	807	230	173	403	41	42	83
*	15-17	435	388	823	252	233	485	154	135	289	29	20	49
*	18-19	1,389	1,834	3,223	146	237	383	1,067	1,446	2,513	177	151	328
*	20	846	963	1,809	69	120	189	697	777	1,474	80	66	146
*	21	708	856	1,564	59	124	183	579	657	1,236	69	76	145
*	22-24	1,249	1,260	2,509	160	240	400	948	898	1,846	141	113	254
*	25-29	1,808	1,719	3,527	289	374	663	1,296	1,163	2,461	223	179	402
*	30-34	1,363	1,252	2,615	277	351	628	927	765	1,692	159	136	295
*	35-39	1,151	993	2,144	332	379	711	713	537	1,250	107	77	184
*	40-44	995	987	1,982	334	423	757	595	508	1,103	66	56	122
*	45-49	972	865	1,837	362	376	738	584	467	1,051	26	22	48
*	50-54	712	728	1,440	250	341	591	439	367	806	22	20	42
*	55-59	448	479	927	189	255	444	243	208	453	14	15	29
*	60-61	128	160	288	66	92	158	58	65	123	4	3	7
*	62-64	214	251	465	118	161	279	90	81	171	6	9	15
*	65-66	109	183	292	66	120	186	39	60	99	4	3	7
*	67-69	156	230	395	88	140	228	62	93	155	6	6	12
*	70-74	262	436	698	151	269	420	103	159	262	8	16	24
*	75-79	225	430	655	108	213	321	117	209	326	0	8	8
*	80-84	133	340	473	72	161	233	60	171	231	1	8	9
*	85+	123	429	552	57	153	210	64	289	353	2	7	9

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-10a-2

Health PD	American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races			Some Other Race			Age Group
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
10a	0	0	0	10	10	20	0	1	1	9	4	13	4	2	6	<1
*	2	0	2	33	36	69	2	3	20	19	39	3	7	10	14	1-4
*	0	0	0	45	37	82	2	1	3	17	29	37	8	8	16	5-9
*	0	2	2	18	21	39	1	1	2	16	14	30	6	4	10	10-14
*	1	1	2	8	13	21	0	0	0	13	4	17	7	2	9	15-17
*	4	2	6	98	98	196	1	2	3	54	29	83	20	20	40	18-19
*	5	1	6	46	43	89	2	0	2	17	13	30	10	9	19	20
*	1	1	2	40	44	84	0	1	1	22	18	40	6	12	18	21
*	3	5	8	109	76	176	2	0	2	19	19	38	17	13	30	22-24
*	3	2	5	162	141	303	2	0	2	31	27	58	25	10	35	25-29
*	6	0	6	114	113	227	2	2	4	22	16	38	14	5	19	30-34
*	4	2	6	76	65	141	3	1	4	14	7	21	10	2	12	35-39
*	2	0	2	40	36	76	1	0	1	19	15	34	4	4	8	40-44
*	2	2	4	13	13	26	0	0	0	9	5	14	3	2	5	45-49
*	2	0	2	10	8	19	1	0	1	8	16	1	2	3	5	50-54
*	1	1	2	0	8	14	0	0	0	6	7	13	1	0	1	55-59
*	1	0	1	1	2	3	0	0	0	2	1	3	0	0	0	60-61
*	0	0	0	6	5	11	0	0	0	0	3	3	0	0	1	62-64
*	1	1	2	2	2	4	0	0	0	1	0	1	0	0	0	65-66
*	0	0	0	1	5	6	0	0	0	5	1	6	0	0	0	67-69
*	1	0	1	5	5	10	0	0	0	1	4	5	1	0	1	70-74
*	0	1	0	0	2	2	0	0	0	5	5	0	0	0	0	75-79
*	0	0	0	0	3	3	0	0	0	1	6	7	0	0	0	80-84
*	0	1	1	2	2	4	0	0	0	0	3	3	0	1	1	85+

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-10a-3

Health PD	Hispanic Alone			Non-Hispanic White			Non-Hispanic Black			Non-Hispanic Other			Age Group	Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
10a	5	13	19	81	78	159	8	19	27	10	14	24	<1	10a
*	19	7	26	162	142	304	287	315	574	55	61	116	1-4	*
*	15	16	31	181	205	386	423	423	846	67	64	134	5-9	*
*	11	12	23	224	166	390	419	387	838	36	39	72	10-14	*
*	17	10	27	146	129	275	251	231	502	21	18	42	15-17	*
*	62	61	123	1,029	1,409	2,438	145	236	290	154	128	308	18-19	*
*	38	27	65	670	758	1,428	68	120	186	70	58	126	20	*
*	21	36	57	567	644	1,211	59	124	183	60	63	120	21	*
*	44	35	79	926	881	1,807	159	247	318	120	96	240	22-24	*
*	66	44	110	1,257	1,135	2,392	285	373	570	200	167	400	25-29	*
*	42	23	65	901	750	1,651	276	350	552	144	129	288	30-34	*
*	23	11	34	701	529	1,230	331	379	662	97	74	194	35-39	*
*	13	16	29	588	498	1,086	334	423	668	60	50	120	40-44	*
*	12	12	24	575	460	1,035	362	375	724	23	19	46	45-49	*
*	6	6	12	435	363	798	250	341	500	20	18	40	50-54	*
*	6	7	13	242	204	446	187	252	374	14	15	28	55-59	*
*	0	1	1	58	64	122	66	92	132	4	3	8	60-61	*
*	2	3	5	88	79	187	118	161	236	6	8	12	62-64	*
*	0	0	2	39	60	99	64	120	184	4	3	8	65-66	*
*	1	3	4	62	91	153	88	139	176	5	6	10	67-69	*
*	0	1	1	103	159	262	151	268	302	8	8	16	70-74	*
*	1	0	1	116	209	325	108	213	216	0	8	0	75-79	*
*	1	3	4	60	171	231	71	150	142	1	7	2	80-84	*
*	0	3	3	64	269	333	57	151	114	2	6	4	85+	*

* Please be advised that the numbers in the health PD tables are estimates based on the geographic overlap of health PD with census tracts. Only cell-specific estimates from these tables should be used; the total numbers from these estimates may be off by several individuals due to rounding errors and should not be used.

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-10b-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
10b	<1	178	184	362	5	4	9	163	168	331	10	12	22
*	1-4	737	718	1,455	14	12	26	685	663	1,348	38	43	81
*	5-9	955	1,004	1,959	27	29	56	888	939	1,827	40	36	76
*	10-14	1,038	1,062	2,100	27	35	62	972	983	1,955	39	45	84
*	15-17	666	677	1,343	23	16	39	625	635	1,260	18	26	44
*	18-19	537	650	1,187	27	37	64	501	596	1,097	26	27	53
*	20	279	306	585	10	6	16	258	293	551	12	7	19
*	21	283	324	607	4	9	13	264	308	572	15	8	23
*	22-24	802	982	1,784	19	25	44	734	930	1,664	49	28	77
*	25-29	1,534	1,721	3,245	38	33	72	1,403	1,621	3,024	82	67	149
*	30-34	1,364	1,452	2,816	27	30	57	1,278	1,354	2,632	59	67	126
*	35-39	1,299	1,520	2,819	27	30	57	1,214	1,432	2,646	58	59	117
*	40-44	1,553	1,789	3,342	31	42	73	1,479	1,709	3,188	43	38	81
*	45-49	1,683	1,934	3,597	26	35	61	1,594	1,855	3,449	44	45	89
*	50-54	1,638	1,729	3,367	25	33	58	1,578	1,666	3,244	35	31	66
*	55-59	1,103	1,266	2,369	23	30	53	1,058	1,211	2,269	21	25	46
*	60-61	353	408	761	7	16	23	335	385	720	11	7	18
*	62-64	473	568	1,041	10	15	25	456	543	999	8	10	18
*	65-66	280	346	626	5	10	15	270	332	602	5	4	9
*	67-69	429	503	932	10	15	25	414	482	896	5	5	10
*	70-74	386	454	840	7	16	23	369	418	787	9	9	17
*	75-79	625	1,031	1,656	8	25	33	613	1,000	1,613	4	7	11
*	80-84	438	832	1,270	5	15	20	429	811	1,240	4	7	11
*	85+	355	983	1,338	0	11	11	354	965	1,319	2	7	9

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-11-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
11	<1	287	261	548	106	81	187	110	117	227	71	63	134
*	1-4	1,014	896	1,910	374	336	710	420	361	781	220	200	420
*	5-9	1,080	956	2,036	429	365	794	481	408	889	170	183	353
*	10-14	913	883	1,796	331	309	640	454	384	838	137	121	258
*	15-17	812	804	1,616	183	201	384	309	269	578	120	94	214
*	18-19	592	603	1,195	115	152	267	338	369	707	139	82	221
*	20	341	323	664	55	88	143	194	189	383	91	46	137
*	21	365	321	686	50	101	151	215	179	394	100	41	141
*	22-24	1,173	963	2,136	210	277	487	631	522	1,153	332	164	496
*	25-29	1,890	1,560	3,450	333	471	804	1,048	806	1,854	509	284	793
*	30-34	1,512	1,250	2,768	267	364	631	842	707	1,549	383	196	569
*	35-39	1,472	1,309	2,781	307	388	695	904	781	1,685	261	141	402
*	40-44	1,361	1,180	2,541	324	378	702	855	722	1,577	182	81	263
*	45-49	1,103	1,042	2,145	275	268	543	702	677	1,379	126	96	222
*	50-54	875	837	1,712	183	198	381	601	573	1,174	92	66	158
*	55-59	579	658	1,237	111	134	245	406	482	888	62	42	104
*	60-64	225	206	425	46	30	82	161	154	315	18	10	28
*	65-69	283	354	637	60	62	122	208	282	490	15	10	25
*	70-74	168	206	374	39	42	81	116	151	267	13	13	26
*	75-79	219	372	591	35	55	90	175	305	480	9	11	20
*	80-84	385	649	1,034	57	69	126	314	569	883	14	12	26
*	85+	279	560	839	42	65	107	227	488	715	11	8	19
*	85+	161	418	579	26	73	99	134	333	469	1	10	11
*	85+	108	405	513	15	86	101	89	313	402	4	6	10

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-11-2

Health PD	* Other Races in Detail												Age Group			
	American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races				Some Other Race		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		Male	Female	Total
11	1	1	2	11	9	20	2	2	4	22	17	39	35	34	69	-1
*	4	4	8	42	40	82	2	2	4	65	55	120	108	99	207	1-4
*	2	3	5	45	44	89	3	1	4	61	53	114	59	82	141	5-9
*	1	3	4	35	24	59	1	4	5	43	34	77	58	56	114	10-14
*	1	3	4	30	34	64	1	2	3	28	21	49	60	35	95	15-17
*	3	0	3	24	17	41	0	2	2	28	26	54	85	37	122	18-19
*	0	1	1	12	12	24	3	1	4	14	10	24	64	22	86	20
*	2	0	2	14	8	22	0	0	0	21	8	29	63	25	88	21
*	2	3	5	39	41	80	3	3	6	44	40	84	244	76	320	22-24
*	7	6	13	86	90	186	6	3	9	83	56	139	317	130	447	25-29
*	2	4	6	49	45	94	11	9	4	13	69	46	115	232	88	303
*	6	6	11	69	41	90	3	3	6	57	39	96	149	54	203	30-34
*	4	1	5	47	27	74	2	1	3	42	22	64	87	30	117	35-39
*	5	6	11	31	38	69	1	3	4	33	24	57	56	25	81	40-44
*	6	3	9	32	33	65	1	0	1	20	14	34	32	16	48	50-54
*	4	2	6	22	23	45	1	0	1	17	9	26	19	7	26	55-59
*	1	2	3	5	4	9	0	0	0	4	3	7	7	1	8	60-64
*	1	1	2	7	4	11	0	2	2	5	1	6	2	3	5	65-69
*	0	1	1	11	9	20	0	0	0	1	3	4	1	0	1	65-66
*	0	0	0	7	6	13	0	0	0	2	3	5	0	2	2	67-69
*	0	0	0	5	2	7	0	0	0	6	8	14	4	2	6	70-74
*	0	0	0	4	3	7	0	0	0	6	3	9	1	2	3	75-79
*	0	2	2	1	3	4	0	0	0	0	2	2	0	0	3	80-84
*	0	1	1	2	3	5	0	0	0	2	1	3	0	2	2	85+

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-11-3

Health PD	Hispanic Alone			Non-Hispanic White			Non-Hispanic Black			Non-Hispanic Other			Age Group	Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
11	67	59	126	85	93	178	104	80	208	30	30	60	1-4	11
*	190	167	357	353	384	657	369	334	703	102	91	204	5-9	*
*	119	136	255	430	359	789	429	363	858	103	99	206	10-14	*
*	111	79	190	415	382	777	313	374	626	75	67	150	15-17	*
*	108	59	167	268	247	515	182	199	364	54	59	108	18-19	*
*	143	71	214	287	338	625	114	151	228	48	42	96	20	*
*	105	37	142	161	174	335	53	87	106	22	24	44	21	*
*	113	37	150	175	167	342	50	100	100	28	17	56	22-24	*
*	382	359	821	408	481	879	209	276	419	74	77	148	25-29	*
*	512	529	741	877	723	1,600	329	468	658	171	141	342	30-34	*
*	382	155	517	730	653	1,383	284	358	568	136	90	272	35-39	*
*	241	104	345	817	741	1,558	305	383	610	109	81	218	40-44	*
*	128	59	187	821	698	1,519	321	374	642	90	50	180	45-49	*
*	106	54	160	658	550	1,308	273	266	546	66	72	132	50-54	*
*	62	35	100	570	558	1,128	181	196	367	60	48	120	55-59	*
*	36	15	51	380	477	866	110	134	220	44	32	88	60-64	*
*	12	3	15	156	152	308	46	35	92	11	9	22	65-69	*
*	7	5	12	204	281	485	60	62	120	12	6	24	70-74	*
*	3	1	4	115	151	266	39	42	78	12	12	24	75-79	*
*	0	4	4	175	303	478	35	55	70	9	9	18	80-84	*
*	6	4	10	310	567	877	57	66	114	11	10	22	85+	*
*	2	5	7	227	485	712	42	64	84	9	6	18	85+	*
*	2	2	4	132	335	467	26	73	52	1	8	2	85+	*
*	2	3	5	88	312	400	14	86	28	4	5	8	85+	*

* Please be advised that the numbers in the health PD tables are estimates based on the geographic overlap of health PD with census tracts. Only cell-specific estimates from these tables should be used, the total numbers from these estimates may be off by several individuals due to rounding errors and should not be used.

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-12-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
12	<1	635	594	1,229	124	133	257	378	361	739	133	100	233
*	1-4	2,197	2,083	4,280	486	400	886	1,301	1,268	2,569	410	415	825
*	5-9	2,408	2,291	4,699	587	597	1,184	1,405	1,330	2,735	416	364	780
*	10-14	2,254	2,084	4,338	558	509	1,067	1,369	1,243	2,614	327	329	656
*	15-17	1,318	1,257	2,575	291	276	567	788	799	1,587	239	182	421
*	18-19	959	904	1,863	179	215	394	594	544	1,138	188	141	329
*	20	536	509	1,045	133	111	244	294	315	609	109	83	192
*	21	539	561	1,100	96	124	220	342	348	690	101	89	190
*	22-24	2,249	2,414	4,663	432	526	958	1,445	1,633	3,078	372	255	627
*	25-29	4,478	4,447	8,925	718	936	1,654	3,064	3,017	6,081	696	494	1,190
*	30-34	3,907	3,508	7,415	640	682	1,302	2,725	2,653	5,378	542	393	935
*	35-39	3,442	3,447	6,889	600	665	1,265	2,410	2,472	4,881	422	310	732
*	40-44	2,936	3,165	6,101	507	648	1,155	2,155	2,269	4,424	274	248	522
*	45-49	2,684	2,884	5,568	413	504	917	2,056	2,179	4,235	215	200	415
*	50-54	2,130	2,368	4,498	283	301	584	1,685	1,925	3,610	161	141	302
*	55-59	1,487	1,677	3,164	155	145	300	1,240	1,461	2,701	91	71	162
*	60-64	451	577	1,031	25	56	81	306	494	800	23	27	60
*	65-69	593	798	1,391	44	53	97	522	713	1,235	27	32	59
*	70-74	441	444	885	18	22	40	361	403	764	22	19	41
*	75-79	508	715	1,223	22	44	66	473	646	1,119	13	25	38
*	80-84	765	1,065	1,830	36	63	99	705	976	1,681	24	36	59
*	85-89	542	781	1,323	31	60	91	629	728	1,357	17	11	28
*	90-94	285	509	794	9	30	39	247	471	717	6	8	14
*	95-100	400	492	892	9	31	40	147	455	602	4	6	10

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-13-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
13	<1	518	455	973	152	124	276	273	251	524	92	79	171
*	1-4	1,748	1,595	3,343	504	480	984	961	876	1,837	283	239	522
*	5-9	1,901	1,824	3,725	639	641	1,280	1,004	921	1,925	238	262	500
*	10-14	1,965	1,988	3,953	629	621	1,250	1,011	921	1,932	240	269	509
*	15-17	935	884	1,819	296	294	590	520	494	1,014	118	96	214
*	18-19	685	642	1,327	235	179	414	369	368	737	82	95	177
*	20	456	370	826	149	88	237	241	234	475	65	48	113
*	21	481	407	888	137	106	243	268	253	521	76	47	123
*	22-24	1,716	1,759	3,475	424	487	911	1,046	1,077	2,123	246	194	440
*	25-29	3,649	3,398	7,047	934	910	1,844	2,276	2,112	4,388	439	377	816
*	30-34	2,365	2,050	4,415	629	558	1,187	1,229	1,060	2,289	262	209	471
*	35-39	3,010	2,762	5,772	821	877	1,698	1,939	1,869	3,808	271	216	487
*	40-44	2,455	2,386	4,841	701	686	1,387	1,557	1,566	3,123	196	134	330
*	45-49	1,839	2,022	3,861	475	558	1,033	1,328	1,344	2,672	136	119	255
*	50-54	1,536	1,656	3,192	394	273	667	1,128	1,293	2,421	114	90	204
*	55-59	1,067	1,137	2,204	131	153	284	863	923	1,786	73	62	135
*	60-64	314	333	647	40	30	70	281	288	569	13	15	28
*	65-64	439	470	909	42	45	87	371	403	774	26	22	48
*	65-60	214	249	463	18	34	52	185	201	386	10	14	24
*	67-69	233	344	577	16	37	53	209	292	501	8	15	23
*	70-74	361	489	850	24	39	63	320	430	750	17	20	37
*	75-79	204	397	601	16	23	39	182	367	549	6	7	13
*	80-84	128	218	346	11	20	31	114	189	303	2	10	12
*	85+	68	178	246	10	15	25	55	160	215	3	3	6

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-13-2

Health PD	* Other Races in Detail												Age Group			
	American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races				Some Other Race		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		Male	Female	Total
13	3	0	3	22	22	44	0	0	0	33	31	64	4	26	30	<1
*	4	3	7	69	66	135	0	3	3	102	83	185	107	83	190	1-4
*	5	6	9	73	89	162	2	0	2	93	75	168	87	93	180	5-9
*	8	6	14	56	66	122	1	4	5	52	51	103	42	43	85	10-14
*	0	1	3	33	35	68	1	0	1	32	26	58	50	33	83	15-17
*	2	3	3	22	37	59	0	1	1	14	15	29	45	36	83	18-19
*	5	3	8	15	14	29	0	0	0	13	12	25	32	20	52	20
*	2	1	3	15	20	35	0	0	0	16	8	24	44	18	62	21
*	6	3	9	56	69	125	2	1	3	38	49	87	143	73	216	22-24
*	10	9	19	137	155	292	3	3	6	74	77	151	215	132	347	25-29
*	11	13	24	134	113	247	5	4	9	90	53	143	167	79	246	30-34
*	8	8	17	91	102	193	4	0	4	63	53	116	104	52	156	35-39
*	7	9	16	89	62	151	2	3	5	43	29	72	54	32	86	40-44
*	11	6	17	55	58	113	2	0	2	31	28	59	37	28	65	45-49
*	11	7	18	60	42	102	2	0	2	18	28	46	23	13	36	50-54
*	4	6	10	42	34	76	0	1	1	14	9	23	13	12	25	55-59
*	1	1	2	6	17	23	0	0	0	5	2	7	1	1	2	60-64
*	1	1	2	15	13	28	0	1	1	7	4	11	3	3	6	65-69
*	0	1	1	9	9	18	0	0	0	1	2	3	0	2	2	70-74
*	1	0	1	7	11	18	0	0	0	5	5	0	0	0	0	75-79
*	0	1	1	10	12	22	2	2	4	2	3	5	2	2	4	80-84
*	0	0	0	2	4	6	0	0	0	1	3	4	3	0	3	85+
*	0	0	0	0	6	6	0	0	0	1	3	4	1	1	2	90-94
*	0	0	0	2	2	4	0	0	0	0	0	0	1	0	1	95-99

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-13-3

Health PD	Hispanic Alone			Non-Hispanic White			Non-Hispanic Black			Non-Hispanic Other			Age Group	Health PD
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
13	70	55	125	245	227	472	150	123	273	32	50	82	<1	13
*	213	174	387	869	794	1,663	500	475	1,000	166	152	332	1-4	*
*	163	163	326	938	852	1,790	632	638	1,264	168	171	336	5-9	*
*	110	97	207	868	773	1,641	576	592	1,152	112	126	238	10-14	*
*	90	67	157	488	460	948	295	290	590	62	67	124	15-17	*
*	100	74	174	320	336	656	232	175	407	33	57	90	18-19	*
*	53	39	92	224	217	441	149	87	238	30	27	60	20	*
*	71	33	104	242	241	483	136	105	272	32	28	64	21	*
*	256	137	393	947	1,022	1,969	419	485	838	94	114	188	22-24	*
*	390	253	643	2,123	2,014	4,137	919	902	1,838	217	230	443	25-29	*
*	301	179	480	2,016	1,723	3,739	826	852	1,653	223	175	398	30-34	*
*	217	129	341	1,813	1,603	3,416	819	874	1,638	161	160	322	35-39	*
*	126	81	207	1,506	1,526	3,032	695	684	1,390	128	96	256	40-44	*
*	74	66	140	1,296	1,311	2,607	473	554	946	95	90	190	45-49	*
*	62	40	102	1,092	1,270	2,362	293	271	564	94	114	178	50-54	*
*	29	27	56	848	910	1,758	129	153	258	60	48	108	55-59	*
*	13	3	13	254	286	540	40	30	40	14	11	25	60-64	*
*	13	11	24	361	395	756	42	45	84	23	19	46	65-66	*
*	5	4	9	182	198	380	18	34	36	9	13	18	68-64	*
*	1	6	7	208	287	495	16	37	32	8	14	16	70-79	*
*	8	8	16	316	424	740	24	39	48	13	18	26	76-74	*
*	5	9	14	181	363	544	16	22	32	3	7	10	75-79	*
*	2	3	5	113	187	300	11	20	22	1	9	9	80-84	*
*	1	2	3	55	158	213	10	15	20	2	2	4		*

* Please be advised that the numbers in the health PD tables are estimates based on the geographic overlap of health PD with census tracts. Only cell-specific estimates from these tables should be used, the total numbers from these estimates may be off by several individuals due to rounding errors and should not be used.

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-14-1

Health PD	Age Group	2000 Population Total			Black or African American			White			Other Races*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
14	<1	547	521	1,068	64	56	120	419	410	829	63	54	117
*	1-4	1,992	1,904	3,896	257	250	507	1,529	1,465	2,994	206	189	395
*	5-9	2,326	2,300	4,626	365	404	769	1,763	1,722	3,485	198	174	372
*	10-14	2,682	2,995	5,677	333	354	687	2,149	2,555	4,704	236	117	353
*	15-17	1,214	1,120	2,334	186	146	332	914	924	1,838	113	50	163
*	18-19	801	708	1,509	94	88	182	605	573	1,178	102	48	150
*	20	397	367	764	48	41	89	295	294	589	54	32	86
*	21	389	375	764	40	38	78	304	299	603	45	39	84
*	22-24	1,528	1,531	3,059	144	177	321	1,195	1,256	2,451	189	97	286
*	25-29	3,534	3,434	6,968	376	407	783	2,812	2,796	5,608	346	231	577
*	30-34	3,450	3,303	6,753	357	381	738	2,821	2,761	5,582	292	181	473
*	35-39	3,432	3,484	6,916	335	409	744	2,945	2,926	5,871	173	140	312
*	40-44	3,006	3,093	6,099	281	309	590	2,595	2,657	5,252	130	126	256
*	45-49	2,581	2,636	5,217	243	243	486	2,270	2,296	4,566	114	97	211
*	50-54	2,094	2,360	4,454	156	181	337	1,854	2,112	3,966	84	67	151
*	55-59	1,503	1,820	3,323	92	83	175	1,365	1,685	3,050	45	53	98
*	60-64	546	625	1,171	24	29	53	508	579	1,087	14	16	30
*	65-64	728	849	1,577	34	31	65	676	789	1,465	17	29	46
*	65-60	380	526	906	11	20	31	361	500	861	9	6	15
*	67-69	573	747	1,320	17	15	32	547	724	1,271	10	7	17
*	70-74	897	1,144	2,041	20	23	43	871	1,105	1,976	7	16	23
*	75-79	619	1,041	1,660	12	27	39	603	1,004	1,607	4	10	14
*	80-84	345	725	1,070	7	21	28	335	697	1,032	4	6	10
*	85+	267	860	1,127	4	12	16	263	847	1,110	0	1	1

Data Table 8. Population by Race, Ethnicity, Age, Gender, and Public Health Planning District (PD), Nashville, TN, 2000
2000 Census Data, Table 8-14-2

Data Table 9. Population by Race, Ethnicity, Gender, and Council District (1991-2002), Nashville, TN, 2000

Council District	2000 Population Total			Black or African American			White			Other Races*			* Other Races in Detail												Hispanic Alone					
													American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races			Some Other Race					
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1	7,066	8,048	15,114	2,602	3,202	5,804	4,293	4,656	8,949	171	190	361	27	26	53	23	35	58	1	2	3	90	107	197	30	20	50	62	51	113
2	6,891	8,207	15,098	5,462	6,815	12,277	1,144	1,163	2,307	285	229	514	10	12	22	37	30	67	4	3	7	102	91	193	132	93	225	215	163	378
3	7,178	8,232	15,410	1,915	2,357	4,272	4,877	5,527	10,404	386	348	734	15	20	35	84	105	189	10	1	11	111	106	217	166	116	282	309	191	500
4	7,854	8,936	16,790	4,634	5,819	10,453	2,804	2,831	5,635	416	286	702	20	19	39	87	87	174	1	0	1	128	100	228	180	80	260	290	128	418
5	6,431	7,408	13,839	4,538	5,539	10,077	1,497	1,517	3,014	396	352	748	21	16	37	28	25	53	3	1	4	168	178	346	176	132	308	308	226	534
6	6,781	7,401	14,182	2,540	3,208	5,748	3,736	3,776	7,512	505	417	922	43	28	71	86	81	167	16	36	52	218	184	402	142	88	230	238	135	373
7	7,194	7,717	14,911	3,099	3,619	6,718	3,752	3,826	7,578	343	272	615	31	22	53	72	63	135	1	0	1	109	119	228	130	68	198	235	130	365
8	7,358	8,179	15,537	1,210	1,388	2,598	5,626	6,368	11,994	522	425	947	45	30	75	79	86	165	0	2	2	163	159	322	235	148	383	326	220	546
9	8,474	8,902	17,376	1,418	1,724	3,142	6,319	6,647	12,966	737	531	1,268	50	38	88	52	70	122	10	10	20	200	179	379	425	234	659	803	454	1,257
10	7,651	8,362	16,013	940	1,073	2,013	6,459	7,041	13,500	252	248	500	25	19	44	64	86	150	1	1	2	92	96	188	70	46	116	135	103	238
11	8,104	8,859	16,963	550	613	1,163	7,258	7,959	15,217	296	287	583	30	35	65	72	90	162	1	1	2	99	98	197	94	63	157	218	163	381
12	10,155	11,085	21,240	1,229	1,375	2,604	8,291	9,168	17,459	635	542	1,177	37	42	79	163	169	332	5	4	9	201	154	355	229	173	402	466	342	808
13	9,224	8,040	17,264	1,362	1,402	2,764	5,797	5,441	11,238	2,065	1,197	3,262	37	36	73	282	260	542	27	18	45	472	334	806	1,247	549	1,796	2,117	988	3,105
14	7,013	7,360	14,373	762	828	1,590	5,933	6,253	12,186	318	279	597	36	28	64	83	93	176	4	3	7	84	76	160	111	79	190	248	183	431
15	7,634	7,669	15,303	539	467	1,006	6,116	6,649	12,765	979	553	1,532	38	25	63	87	100	187	4	0	4	148	133	281	702	295	997	1,003	487	1,490
16	7,353	7,086	14,439	776	880	1,656	5,125	5,243	10,368	1,452	963	2,415	25	18	43	342	308	650	14	8	22	269	208	477	802	421	1,223	1,287	667	1,954
17	5,780	6,761	12,541	3,175	4,037	7,212	2,348	2,472	4,820	257	252	509	11	14	25	100	114	214	3	2	5	94	94	188	49	28	77	135	74	209
18	7,051	7,595	14,646	352	499	851	5,863	6,357	12,220	836	739	1,575	19	7	26	610	552	1,162	15	9	24	136	108	244	56	63	119	196	195	391
19	6,669	6,981	13,650	4,064	4,817	8,881	2,186	1,854	4,040	419	310	729	18	16	34	137	127	264	3	12	15	151	106	257	110	49	159	276	174	450
20	6,549	7,117	13,666	5,583	6,369	11,952	775	598	1,373	191	150	341	26	12	38	20	22	42	8	7	15	77	78	155	60	31	91	124	51	175
21	7,192	7,930	15,122	4,348	5,544	9,892	2,258	2,003	4,261	586	383	969	21	20	41	140	136	276	4	4	8	135	123	258	286	100	386	515	228	743
22	8,511	6,311	14,822	1,908	656	2,564	5,815	5,019	10,834	788	636	1,424	35	25	60	434	370	804	5	6	11	189	159	348	125	76	201	258	173	431
23	8,582	9,134	17,716	476	476	952	7,526	8,118	15,644	580	540	1,120	21	16	37	315	292	607	3	5	8	174	158	332	67	69	136	175	184	359
24	7,190	7,869	15,059	688	867	1,555	6,019	6,633	12,652	483	369	852	23	21	44	221	170	391	2	6	8	150	127	277	87	45	132	197	144	341
25	7,154	8,538	15,692	172	224	396	6,690	8,070	14,760	292	244	536	13	16	29	168	141	309	12	3	15	77	68	145	22	16	38	86	91	179
26	8,261	8,356	16,617	1,683	1,845	3,528	4,910	5,243	10,153	1,668	1,268	2,936	32	18	50	287	267	554	9	8	17	530	467	997	810	508	1,318	1,391	902	2,293
27	9,021	8,052	17,073	2,697	2,080	4,777	5,323	5,103	10,426	1,001	869	1,870	40	26	66	398	367	765	4	3	7	245	258	503	314	525	647	460	1,107	
28	10,358	10,779	21,137	2,549	2,970	5,519	6,558	6,648	13,206	1,251	1,161	2,412	30	31	61	526	542	1,068	12	15	27	291	257	548	392	316	708	876	736	1,612
29	10,306	10,880	21,186	2,565	2,985	5,550	6,963	7,237	14,200	678	658	1,336	26	28	54	270	307	577	4	4	8	193	171	364	185	148	333	363	320	683
30	7,469	7,461	14,930	1,595	1,645	3,240	4,720	4,907	9,627	1,154	909	2,063	18	19	37	243	247	490	4	7	11	260	223	483	629	413	1,042	1,068	702	1,770
31	10,266	10,870	21,136	1,974	2,368	4,342	7,367	7,669	15,036	925	833	1,758	20	27	47	364	393	757	5	5	10	244	218	462	292	190	482	586	443	1,029
32	9,192	10,120	19,312	605	683	1,288	7,899	8,840	16,739	688	597	1,285	20	20	40	307	264	571	5	5	10	126	138	264	230	170	400	453	316	769
33	7,203	7,974	15,177	90	84	174	6,929	7,708	14,637	184	182	366	9	5	14	107	109	216	1	5	6	48	42	90	19	21	40	66	64	130
34	6,894	8,308	15,202	54	92	146	6,688	8,031	14,719	152	185	337	13	8	21	74	89	163	0	2	2	49	60	109	16	26	42	75	81	156
35	9,856	11,499	21,355	404	490	894	8,926	10,418	19,344	526	591	1,117	29	22	51	331	385	716	1	3	4	111	128	239	54	53	107	184	189	373
Total	275,865	294,026	569,891	68,658	79,038	147,696	184,790	196,993	381,783	22,417	17,995	40,412	914	765	1,679	6,693	6,582	13,275	202	201	403	5,934	5,305	11,239	8,674	5,142	13,816	15,933	10,158	26,091

Source: Metropolitan Planning Commission, 2002

* Metropolitan Council District (1991-2002)

Data Table 10. 2000 Census Population by Age, Gender, and Council District (1991-2002), Nashville, TN
2000 Census Data, Table 10-1

Council District	White Male																							Sum
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+	
1	225	247	256	203	104	42	39	111	246	267	303	375	376	366	282	103	155	69	123	174	115	64	48	4,293
2	60	83	70	49	32	11	13	47	57	74	104	97	88	103	68	18	21	19	37	47	21	20	5	1,144
3	247	208	232	130	246	80	69	205	362	306	359	384	362	331	245	109	160	90	138	237	191	111	75	4,877
4	171	184	153	90	93	64	31	106	168	178	232	236	216	195	141	48	82	44	81	118	106	33	34	2,804
5	103	108	90	50	40	18	16	59	102	139	124	133	117	99	79	33	37	24	27	54	21	13	11	1,497
6	201	188	159	91	79	32	21	118	283	434	476	396	365	278	169	65	74	46	58	81	63	41	18	3,736
7	197	197	190	101	260	87	64	131	240	263	318	292	286	234	179	78	90	56	73	151	142	81	42	3,752
8	301	299	319	184	166	69	75	179	335	459	516	509	519	381	259	91	123	72	131	198	210	126	105	5,626
9	437	417	396	237	231	102	84	287	505	504	548	496	457	395	302	113	155	104	119	159	123	74	74	6,319
10	390	354	364	199	154	74	83	259	526	459	530	534	476	463	409	138	196	105	178	233	178	108	49	6,459
11	494	487	501	265	156	59	71	236	486	615	712	616	588	505	374	147	190	104	144	202	153	76	76	7,258
12	593	502	428	252	163	99	92	435	935	872	895	757	568	483	338	108	157	80	102	156	102	83	91	8,291
13	397	270	263	136	149	89	113	391	748	654	581	479	429	309	231	99	80	47	63	112	78	54	25	5,797
14	339	304	283	179	129	66	66	266	684	589	557	535	452	378	256	104	160	59	127	201	115	51	33	5,933
15	382	347	265	176	123	63	53	189	495	490	544	529	504	367	320	124	155	107	161	301	229	123	66	6,116
16	271	288	289	195	151	63	69	237	459	390	498	484	385	322	228	83	126	67	106	176	133	62	43	5,125
17	101	79	75	46	37	79	70	210	292	270	242	201	230	149	78	26	23	13	33	30	31	20	13	2,348
18	131	105	128	80	1,022	598	457	515	676	484	353	329	296	228	118	33	47	19	34	66	73	35	36	5,863
19	54	32	58	53	105	77	84	195	316	235	208	199	140	136	94	29	33	17	26	36	23	22	14	2,186
20	20	21	10	4	16	12	12	55	118	104	110	86	53	44	35	12	11	7	10	18	8	6	3	775
21	84	70	57	36	53	39	74	258	374	243	220	151	161	104	76	27	45	19	30	45	42	24	26	2,258
22	290	266	264	170	130	105	95	310	538	553	528	551	515	373	298	92	139	93	122	177	115	66	25	5,815
23	463	396	383	213	140	61	71	465	860	656	639	599	634	526	423	114	188	91	132	195	180	93	64	7,526
24	560	276	301	153	114	53	74	235	620	690	535	580	502	426	269	83	104	76	108	217	169	108	56	6,019
25	267	254	259	199	298	175	164	425	710	539	444	497	492	505	348	105	139	74	126	227	201	132	110	6,690
26	280	246	236	145	107	68	68	258	513	464	421	372	389	279	244	85	121	80	122	178	109	89	50	4,910
27	297	274	235	147	114	77	114	371	675	603	547	463	375	303	213	55	84	48	60	119	84	46	21	5,323
28	419	320	289	172	124	98	111	499	1,017	784	635	489	429	349	274	90	134	73	65	98	36	34	19	6,558
29	524	467	450	237	129	65	51	185	601	756	756	631	539	538	373	106	154	74	88	116	67	36	20	6,963
30	297	288	249	179	131	67	65	229	478	432	412	392	351	290	254	63	98	76	102	125	81	35	26	4,720
31	501	355	330	180	133	78	111	513	1,051	903	743	596	527	464	303	110	115	66	73	110	56	32	17	7,367
32	494	394	418	240	171	67	79	383	907	777	707	644	649	535	375	116	156	115	141	225	184	86	36	7,899
33	345	442	503	287	134	31	45	158	277	368	443	575	687	699	443	130	205	115	161	288	276	178	139	6,929
34	429	432	433	207	87	22	37	126	380	456	483	544	577	535	442	124	172	119	193	289	271	192	138	6,688
35	722	632	546	318	154	73	64	240	652	807	878	829	758	631	436	141	204	97	179	236	167	115	47	8,926
Sum	10,886	9,832	9,482	5,587	5,475	2,863	2,805	8,285	17,686	16,731	16,601	15,580	14,493	12,323	8,976	3,002	4,133	2,365	3,473	5,395	4,153	2,469	1,655	184,790

Data Table 10. 2000 Census Population by Age, Gender, and Council District (1991-2002), Nashville, TN
2000 Census Data, Table 10-2

Council District	White Female																								Sum
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+		
1	216	227	236	167	76	36	45	131	268	313	382	440	386	346	267	98	127	82	134	200	178	125	176	4,656	
2	62	62	71	32	24	8	17	34	63	62	96	90	81	78	65	24	44	27	44	65	56	33	25	1,163	
3	230	212	234	160	97	58	66	201	333	327	350	388	396	354	308	148	203	137	202	360	293	199	271	5,527	
4	151	152	142	82	70	31	32	109	174	171	200	224	217	167	171	54	82	79	93	176	118	81	55	2,831	
5	87	112	77	36	45	17	21	56	94	137	99	130	98	105	74	28	40	33	37	71	39	45	36	1,517	
6	193	148	188	102	69	57	23	111	343	349	371	317	290	235	226	69	85	60	89	149	132	89	81	3,776	
7	177	194	176	107	82	39	38	148	224	267	275	271	287	234	225	60	109	62	134	236	210	146	125	3,826	
8	262	286	284	162	131	65	55	188	359	436	484	515	483	362	292	109	152	122	212	390	397	317	305	6,368	
9	406	376	346	199	157	102	70	258	471	446	518	539	480	436	396	150	191	109	144	270	272	161	150	6,647	
10	395	365	332	197	144	67	73	247	490	480	556	565	557	480	475	197	225	127	222	291	242	170	144	7,041	
11	470	512	454	279	149	58	52	229	540	612	704	669	589	586	444	170	218	128	185	316	255	178	162	7,959	
12	616	487	417	218	177	117	116	488	1,016	863	909	718	649	544	380	117	142	98	138	178	212	209	359	9,168	
13	302	245	208	131	124	78	76	307	603	558	496	446	424	344	249	71	118	60	105	179	161	98	58	5,441	
14	351	305	284	171	117	62	69	292	591	559	551	519	406	427	369	117	183	114	164	209	180	100	113	6,253	
15	319	306	307	204	105	41	47	182	420	465	526	537	462	393	395	151	207	149	222	389	360	217	245	6,649	
16	269	260	234	169	118	66	51	205	352	357	433	414	384	329	296	86	163	83	169	313	226	149	117	5,243	
17	87	70	51	55	54	101	124	199	297	255	209	191	203	139	87	20	39	18	41	50	63	67	72	2,472	
18	108	131	121	85	1,398	658	501	535	661	424	283	273	242	192	101	34	35	38	42	98	131	106	160	6,357	
19	57	50	32	30	149	85	92	155	176	125	92	86	83	88	68	27	46	23	32	98	99	69	92	1,854	
20	18	18	7	6	10	6	10	39	65	47	48	47	38	44	42	9	9	12	26	23	27	28	19	598	
21	84	69	53	38	43	37	51	216	271	165	138	134	116	96	79	18	35	22	58	77	73	53	77	2,003	
22	255	271	260	167	99	81	79	203	354	293	388	434	383	366	267	104	144	117	164	225	180	109	76	5,019	
23	391	365	381	223	118	77	90	501	842	681	656	655	641	590	423	155	192	100	154	337	225	152	169	8,118	
24	325	269	252	157	117	64	69	261	622	603	547	564	535	423	303	113	143	111	164	292	296	230	173	6,633	
25	244	280	275	167	387	205	205	562	843	541	493	543	595	546	429	122	183	100	162	346	319	241	282	8,700	
26	308	210	186	163	106	71	68	265	421	366	429	380	336	330	266	110	163	106	178	169	160	165	5,243		
27	259	229	129	127	69	84	84	312	629	470	409	410	390	310	210	108	81	119	110	141	129	79	51	5,103	
28	399	328	254	162	154	102	132	713	910	645	523	502	406	434	320	106	132	55	92	146	121	67	85	6,648	
29	492	403	407	228	115	56	54	216	635	733	732	712	626	597	409	120	170	91	107	131	112	57	34	7,237	
30	281	250	243	135	121	65	65	234	392	371	395	382	366	336	290	97	149	87	126	190	125	77	130	4,907	
31	482	368	340	182	151	89	106	590	1,061	796	691	658	598	508	335	108	135	70	94	115	110	60	22	7,669	
32	445	397	373	225	124	78	91	495	1,017	793	797	699	718	637	495	140	219	114	191	320	221	115	106	8,840	
33	358	388	472	300	114	30	34	117	326	391	540	716	751	688	458	154	224	128	201	366	418	250	275	7,708	
34	383	472	435	255	68	30	36	160	414	465	568	614	677	596	458	137	216	158	200	393	440	384	471	8,031	
35	693	624	582	331	152	52	77	308	768	904	1,009	1,051	1,052	911	715	529	193	231	145	223	311	285	179	85	10,418
Sum	10,175	9,432	8,983	5,484	5,292	2,858	2,819	9,128	17,045	15,470	15,987	15,842	14,783	13,085	10,190	3,506	4,873	3,024	4,659	7,720	6,893	4,829	1,966	196,995	

Data Table 10. 2000 Census Population by Age, Gender, and Council District (1991-2002), Nashville, TN
2000 Census Data, Table 10-3

Council District	Black Male																							Sum
	<5	5-9	10-14	15-17	18-19	20-21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+		
1	120	170	196	204	83	40	27	91	124	119	147	174	198	219	185	75	84	49	74	90	59	37	37	2,602
2	458	517	523	318	191	77	83	209	321	328	336	361	345	352	269	100	149	76	135	134	88	58	34	5,462
3	178	202	183	86	63	28	32	97	164	166	173	151	113	125	45	16	24	10	13	14	14	11	7	1,915
4	517	582	552	306	160	51	83	201	322	300	336	330	287	235	146	46	44	25	25	51	23	8	4	4,634
5	428	559	559	292	162	55	69	159	258	282	306	338	286	215	148	60	70	43	80	81	42	25	21	4,538
6	392	347	324	168	80	34	26	101	143	169	196	150	132	95	52	14	21	17	21	25	18	11	4	2,540
7	361	318	309	188	123	45	27	104	175	191	217	249	214	168	116	40	52	30	49	59	27	26	11	3,099
8	97	105	129	85	42	20	29	48	96	82	125	119	79	59	35	11	8	2	10	17	5	5	2	1,210
9	141	146	140	75	52	28	20	78	132	146	133	100	84	58	33	5	13	7	6	10	3	5	3	1,418
10	87	106	121	53	40	11	12	28	80	59	76	64	69	47	31	8	16	4	9	11	5	2	1	940
11	64	59	43	24	14	9	6	23	39	48	66	41	41	26	20	7	7	1	4	3	3	1	1	550
12	120	134	145	73	37	16	19	45	133	111	114	91	68	57	27	10	9	3	3	8	2	3	1	1,229
13	114	104	95	58	26	21	23	93	160	171	142	130	83	51	42	15	9	8	4	5	5	0	3	1,362
14	61	107	77	33	17	8	6	32	98	67	67	55	45	33	19	4	7	4	8	4	6	2	2	762
15	49	38	34	29	16	11	7	33	80	68	43	49	33	19	10	2	11	2	2	3	0	0	0	539
16	61	65	40	31	21	10	14	61	108	75	79	76	45	34	10	8	7	3	4	10	7	5	2	776
17	251	308	280	166	77	40	29	93	166	187	228	229	252	192	143	56	92	47	70	99	89	45	36	3,175
18	4	7	17	5	38	15	12	33	40	14	24	22	25	21	10	5	3	10	7	14	11	8	7	352
19	462	401	339	209	193	77	68	149	260	242	307	309	317	203	128	38	79	43	47	89	39	35	30	4,064
20	460	530	504	268	213	101	93	220	368	345	400	442	359	254	210	63	112	75	116	167	141	87	55	5,583
21	306	353	319	184	608	247	175	317	247	227	217	261	201	151	130	37	53	41	57	81	63	48	25	4,348
22	69	52	51	34	77	65	72	205	338	251	251	192	120	96	30	6	9	1	5	6	1	4	0	1,908
23	31	49	42	13	9	12	8	51	76	39	39	34	15	30	15	1	6	0	1	3	1	1	0	476
24	92	74	50	32	11	16	12	45	69	52	51	46	27	20	10	9	6	14	6	2	4	0	0	688
25	7	10	14	9	6	1	3	7	19	15	15	20	10	9	6	1	7	1	3	3	3	3	0	172
26	151	146	102	77	57	39	24	130	202	173	169	152	97	63	43	9	9	5	4	14	13	2	2	1,683
27	173	153	150	70	94	90	73	240	384	309	341	269	161	99	48	8	10	5	5	8	4	2	1	2,697
28	281	249	220	105	73	42	43	158	383	277	237	201	138	62	25	12	12	6	4	6	5	6	2	2,549
29	243	265	273	147	75	37	20	56	189	255	290	285	215	156	75	20	20	6	8	13	9	5	3	2,665
30	175	165	140	64	52	31	29	106	201	167	132	105	92	64	28	5	9	6	8	8	1	3	4	1,595
31	191	186	200	100	51	34	28	124	219	202	182	140	128	90	36	10	15	5	5	12	11	2	3	1,974
32	32	46	54	24	8	10	11	40	57	68	56	53	54	43	29	1	10	1	2	2	2	2	0	605
33	5	5	7	13	3	1	0	0	5	3	5	7	11	7	4	3	2	1	4	3	0	1	0	90
34	3	3	0	1	1	0	0	0	4	5	1	5	7	4	7	2	1	1	0	0	1	7	1	54
35	33	32	47	15	8	5	6	15	31	32	42	35	38	31	14	3	7	0	3	6	1	0	0	404
Sum	6,217	6,593	6,279	3,579	2,781	1,327	1,189	3,396	5,692	5,241	5,547	5,287	4,386	3,361	2,184	710	896	543	810	1,066	712	457	305	68,658

Data Table 10. 2000 Census Population by Age, Gender, and Council District (1991-2002), Nashville, TN
2000 Census Data, Table 10-4

Council District	Black Female																								Sum
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+		
1	129	170	186	124	58	45	32	114	174	155	223	215	274	302	219	84	116	50	92	105	100	83	152	3,202	
2	445	489	520	314	185	92	97	261	413	408	530	522	518	455	389	120	188	135	150	226	159	87	112	6,815	
3	148	213	195	126	57	32	41	131	193	201	223	207	174	153	72	30	46	12	16	25	21	17	34	2,557	
4	497	524	456	284	169	94	80	299	512	496	521	493	466	342	203	64	74	40	53	67	49	23	13	5,819	
5	433	623	541	299	177	72	67	185	356	373	467	449	340	271	192	68	119	74	73	137	101	66	56	5,539	
6	412	346	286	149	115	64	89	166	275	218	267	244	184	102	78	23	40	34	29	28	27	17	15	3,208	
7	279	298	302	170	138	61	70	184	218	254	313	330	260	189	141	50	83	40	55	72	44	37	31	3,619	
8	99	132	109	71	43	21	35	53	119	120	141	129	110	66	45	11	15	11	10	17	12	11	6	1,386	
9	169	145	113	78	69	26	19	91	176	144	173	149	110	88	46	15	24	15	12	21	14	14	13	1,724	
10	93	98	88	48	24	15	8	57	95	96	99	89	88	60	35	9	14	13	13	12	11	4	4	1,073	
11	43	67	43	24	11	2	5	27	51	63	56	56	45	38	28	12	10	1	3	8	8	9	3	613	
12	120	148	132	50	37	15	16	69	167	123	157	107	91	72	18	8	7	8	5	6	6	7	1,375		
13	98	108	78	55	34	21	20	98	200	135	148	128	96	59	49	10	11	6	10	13	15	5	5	1,402	
14	81	100	78	31	24	12	10	43	104	88	87	55	37	30	13	4	5	6	5	5	7	3	0	828	
15	48	49	32	17	9	9	6	21	55	49	59	53	21	25	8	3	8	2	0	3	2	5	3	467	
16	65	65	79	43	17	6	14	62	106	85	83	82	61	39	23	5	5	5	4	8	11	4	8	880	
17	253	282	269	160	100	52	62	149	242	237	277	284	273	251	184	71	119	97	111	189	147	119	109	4,037	
18	6	16	15	10	91	40	39	29	25	18	26	17	16	15	18	7	11	6	9	24	20	23	18	499	
19	400	368	345	196	343	188	142	254	351	289	305	345	250	203	154	42	91	60	78	118	86	102	107	4,817	
20	472	502	531	237	182	89	75	236	370	416	458	501	393	287	248	90	170	141	171	284	223	151	142	6,369	
21	306	315	272	171	978	493	373	379	296	268	285	257	217	185	123	44	50	40	73	125	136	74	84	5,544	
22	43	42	39	21	15	19	25	62	92	75	59	53	34	26	14	4	6	5	5	3	5	5	4	656	
23	27	40	38	23	10	4	14	47	59	47	36	31	34	28	13	2	4	2	7	2	5	2	1	476	
24	96	56	46	26	28	21	31	87	111	42	61	65	44	30	33	10	16	13	14	19	14	2	2	867	
25	5	10	6	4	21	3	5	18	12	20	8	27	13	13	15	4	4	5	5	4	13	5	4	224	
26	147	134	104	61	66	23	49	146	249	175	170	166	117	79	48	18	14	7	20	25	8	9	10	1,845	
27	140	133	143	76	58	45	33	165	269	243	259	201	142	80	41	2	13	4	7	8	5	8	5	2,080	
28	296	252	207	114	70	35	62	238	441	341	311	229	176	81	36	16	14	11	16	14	7	5	2,370		
29	224	291	308	127	67	31	19	92	233	310	318	373	310	283	132	79	20	19	16	10	20	6	2,085		
30	133	147	130	57	54	38	35	133	200	165	158	144	102	62	19	10	6	9	9	12	6	7	9	1,645	
31	185	210	172	102	56	34	27	174	358	217	210	210	178	98	41	18	21	5	11	17	9	7	8	2,368	
32	27	55	51	32	20	6	9	41	75	63	58	77	70	37	22	8	9	1	2	6	5	6	3	683	
33	3	6	13	2	2	0	1	0	4	1	6	9	8	9	4	4	3	1	0	2	4	2	0	84	
34	6	3	5	4	1	0	0	2	6	3	7	10	7	6	4	2	1	4	3	1	9	4	4	92	
35	38	30	34	23	14	10	6	14	24	55	41	49	51	33	35	20	5	7	5	0	3	1	0	490	
Sum	5,936	6,467	5,966	3,329	3,343	1,708	1,616	4,157	6,666	5,987	6,663	6,275	5,265	3,947	2,675	874	1,344	887	1,085	1,627	1,306	932	983	79,038	

Data Table 10. 2000 Census Population by Age, Gender, and Council District (1991-2002), Nashville, TN
2000 Census Data, Table 10-5

Council District	Male Total																							Sum
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+	
1	363	431	461	419	195	83	68	229	381	397	436	466	560	587	593	474	183	242	120	199	269	176	86	7,066
2	562	642	620	377	234	94	100	287	411	422	454	466	445	464	341	121	171	97	173	182	110	79	39	6,891
3	463	436	452	235	324	118	118	329	569	495	563	561	501	476	301	127	186	101	153	255	208	122	84	7,178
4	742	813	730	416	369	125	125	339	529	518	612	588	517	440	296	98	132	69	108	175	132	43	38	7,854
5	571	715	692	358	221	85	91	243	401	460	456	504	417	326	232	94	112	67	109	139	66	39	33	6,415
6	661	581	521	287	180	77	61	246	488	462	713	580	530	393	231	80	97	64	79	110	85	53	22	6,781
7	602	553	529	305	397	140	100	252	451	486	559	562	515	414	307	119	144	90	123	216	169	108	53	7,194
8	455	441	477	287	244	107	118	270	492	587	686	659	631	464	304	108	133	74	145	217	218	131	110	7,358
9	668	624	572	353	322	143	129	442	750	715	729	645	572	476	348	120	171	112	127	172	127	79	78	8,474
10	498	486	503	266	203	89	99	299	633	541	627	615	557	522	457	149	217	111	187	246	186	110	50	7,651
11	588	583	571	305	176	71	83	271	555	698	797	676	646	543	403	156	199	110	152	208	158	78	77	8,104
12	807	706	606	345	219	124	122	511	1,171	1,071	1,061	879	662	561	378	122	170	83	108	166	104	87	92	10,155
13	668	467	426	288	268	174	209	707	1,277	1,117	917	744	598	412	309	128	99	60	69	120	83	29	9	9,224
14	441	442	374	230	153	79	77	315	817	704	648	608	515	425	284	111	171	65	136	205	123	55	35	7,013
15	419	439	346	260	266	113	81	346	736	666	656	631	589	416	340	129	169	110	164	309	229	123	66	7,534
16	473	436	411	283	237	113	125	362	605	630	675	645	498	406	260	115	145	67	114	185	108	68	47	7,880
17	386	410	369	219	128	125	107	321	488	483	494	436	483	355	227	86	119	75	106	129	120	68	49	6,780
18	167	152	166	94	1,213	682	524	652	830	587	449	391	333	255	134	38	54	30	43	85	84	44	44	7,051
19	570	464	411	282	318	167	168	377	639	525	548	533	447	353	231	70	112	60	73	130	63	57	47	6,669
20	499	577	533	278	234	115	109	294	509	466	523	540	418	302	247	76	125	85	128	187	151	93	60	6,549
21	430	449	394	236	683	301	274	649	743	555	481	447	385	265	212	69	101	65	92	131	106	72	52	7,192
22	432	382	358	245	241	181	176	573	982	878	848	793	666	480	360	113	165	102	132	189	120	70	25	8,511
23	542	497	508	243	158	75	81	487	1,008	778	742	673	674	575	460	122	205	96	140	207	185	96	68	8,582
24	506	369	373	226	143	72	94	318	768	718	625	656	551	469	305	97	119	85	124	226	173	117	56	7,190
25	293	276	286	210	323	187	180	459	785	593	482	537	513	526	359	107	147	77	129	233	204	137	111	7,154
26	612	539	456	294	228	146	123	532	960	846	732	609	544	384	313	109	137	91	131	202	127	94	52	8,261
27	580	563	461	253	248	188	214	685	1,187	1,029	973	787	595	442	282	68	103	58	72	132	91	44	28	9,026
28	876	687	584	319	220	166	186	755	1,256	1,099	984	764	618	467	308	165	156	85	70	169	45	29	28	10,381
29	865	807	781	412	220	106	78	289	873	1,091	1,097	963	748	716	473	132	178	121	100	137	77	42	23	10,308
30	608	538	447	308	239	131	122	447	868	717	636	558	492	388	300	99	113	85	112	136	83	39	33	7,469
31	810	633	592	318	203	127	155	683	1,377	1,217	1,020	794	703	585	363	125	133	78	81	131	72	35	21	10,266
32	586	499	520	290	205	91	105	462	1,078	907	832	746	737	611	419	124	174	119	144	228	190	89	36	9,192
33	368	459	523	312	140	34	45	165	298	380	467	596	715	723	455	137	210	117	168	293	279	180	139	7,203
34	442	449	448	211	91	22	37	136	395	468	498	565	592	552	456	131	178	123	194	294	279	193	140	6,894
35	812	718	646	356	170	79	72	268	732	895	969	907	842	685	457	154	222	98	193	247	169	117	48	9,856
Sum	19,466	18,200	17,089	10,120	9,254	4,730	4,558	14,070	26,542	24,511	24,019	22,218	19,891	16,467	11,655	3,874	5,310	3,010	4,378	6,608	4,941	2,961	1,993	275,865

Source: Metropolitan Planning Commission, 2002

* Metropolitan Council District (1991-2002)

Data Table 10. 2000 Census Population by Age, Gender, and Council District (1991-2002), Nashville, TN
2000 Census Data, Table 10-6

Council District	Female Total																							Sum	
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+		
1	359	408	434	305	136	82	81	255	461	480	628	617	670	659	497	185	244	133	227	311	282	209	329	8,048	
2	535	582	613	357	215	102	118	312	498	483	640	628	612	543	460	145	235	166	195	293	218	120	137	8,207	
3	421	457	453	303	167	101	112	352	563	556	595	617	596	524	388	172	255	150	223	391	315	218	305	8,232	
4	684	708	627	379	246	129	117	400	714	686	741	732	698	518	383	150	158	123	140	246	171	105	70	8,936	
5	578	769	627	362	235	91	91	254	481	536	585	597	455	386	273	94	108	163	108	110	413	112	87	7,408	
6	683	537	514	268	206	128	122	302	653	590	663	586	499	350	309	44	133	95	125	170	160	106	99	7,401	
7	508	519	498	291	234	104	113	340	457	533	613	623	562	431	375	115	194	104	193	313	257	184	156	7,717	
8	421	457	417	248	202	94	99	267	512	589	652	672	630	445	346	122	170	137	227	410	415	331	316	8,179	
9	650	585	500	302	244	139	100	376	704	628	731	726	614	540	455	169	217	125	164	295	291	181	166	8,902	
10	512	488	428	261	173	85	85	311	608	596	674	675	663	560	520	212	244	145	238	304	256	176	148	8,382	
11	553	613	519	311	164	63	61	260	619	698	785	753	652	636	480	185	236	132	190	331	263	189	166	8,859	
12	827	683	588	284	224	137	141	584	1,261	1,046	1,117	852	757	636	416	131	159	107	145	185	223	215	367	11,085	
13	550	475	347	252	204	130	119	526	984	794	747	629	563	435	327	90	137	71	118	194	178	105	65	8,040	
14	460	433	373	209	145	76	90	349	729	685	658	597	464	466	392	124	195	121	170	217	190	104	113	7,360	
15	438	397	373	234	140	68	68	250	548	570	627	606	516	439	414	159	217	151	223	395	364	224	248	7,669	
16	469	413	378	262	172	93	86	353	584	533	582	539	501	399	343	93	173	95	181	324	244	161	128	7,088	
17	377	371	339	225	159	104	107	358	565	522	567	464	467	385	274	93	162	117	152	249	242	188	184	6,761	
18	134	184	151	104	1,628	719	659	603	628	779	523	367	321	288	213	127	42	49	45	53	124	156	131	179	7,555
19	491	451	391	233	517	278	243	438	579	449	408	446	343	298	230	70	139	84	111	220	186	174	202	6,981	
20	511	529	545	249	196	96	90	279	451	480	516	557	436	339	298	101	183	154	199	310	252	182	164	7,117	
21	418	414	341	221	1,043	541	437	636	637	473	438	418	345	290	208	64	89	64	136	209	211	133	164	7,930	
22	365	344	352	224	139	104	110	294	518	433	490	540	457	428	312	117	163	125	174	235	190	116	81	6,311	
23	484	450	456	269	136	88	106	564	974	796	742	729	697	647	453	163	205	109	165	341	234	155	171	9,134	
24	454	345	313	192	164	91	109	373	778	694	637	651	605	472	347	127	163	130	183	315	313	235	178	7,869	
25	265	302	293	177	122	213	213	601	899	589	519	579	627	569	451	128	190	106	167	354	334	248	292	8,538	
26	646	470	394	286	215	119	146	503	850	665	678	620	498	430	334	144	185	119	204	282	200	191	177	8,356	
27	497	427	455	240	217	124	138	542	1,009	806	828	664	558	411	257	89	138	69	124	174	138	91	56	8,052	
28	811	696	533	313	269	160	218	924	1,531	1,107	920	792	639	555	376	128	149	74	111	175	100	77	91	10,779	
29	793	767	768	375	301	86	78	341	957	1,111	1,159	948	943	763	514	156	203	112	131	152	126	66	76	10,680	
30	548	478	467	293	220	131	125	418	703	588	627	588	560	429	309	113	166	99	143	229	191	139	74	9,191	
31	754	661	567	321	233	138	153	890	1,524	1,108	980	922	813	643	392	131	162	79	112	137	119	68	33	10,670	
32	529	500	458	315	162	96	107	567	1,159	927	912	818	841	708	531	151	233	119	196	332	228	121	110	10,120	
33	379	406	508	315	122	31	35	120	335	406	562	744	772	712	472	159	231	131	203	369	425	262	275	7,974	
34	406	487	451	268	73	32	39	165	436	480	598	637	698	613	472	141	221	164	209	401	450	392	475	8,308	
35	804	703	658	375	173	67	85	351	890	1,006	1,119	1,165	983	829	567	206	250	154	232	308	293	182	87	11,499	
Sum	18,347	17,524	16,143	9,558	9,399	4,935	4,832	14,420	25,550	23,184	24,029	23,233	20,978	17,698	13,313	4,521	6,409	4,016	5,878	9,508	8,301	5,841	6,009	294,026	

Source: Metropolitan Planning Commission, 2002

* Metropolitan Council District (1991-2002)

Data Table 10. 2000 Census Population by Age, Gender, and Council District (1991-2002), Nashville, TN
2000 Census Data, Table 10-7

Council District	Total																				Sum
	5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-64	67-69	70-74	75-79	
1	722	839	895	724	331	162	149	464	842	877	1,088	1,230	1,366	1,232	971	368	486	253	476	380	415
2	1,097	1,224	1,233	734	449	196	218	599	909	905	1,094	1,094	1,057	1,007	801	266	406	263	368	475	176
3	884	893	905	538	492	219	230	681	1,132	1,051	1,158	1,178	1,097	1,000	689	299	439	251	376	646	389
4	1,436	1,521	1,357	795	515	254	242	759	1,243	1,204	1,353	1,320	1,215	958	679	218	290	192	257	423	108
5	1,149	1,504	1,343	720	456	176	182	497	882	996	1,041	1,101	870	712	505	194	275	175	219	352	151
6	1,344	1,118	1,035	555	386	205	183	548	1,141	1,232	1,376	1,166	1,029	743	540	174	230	159	204	289	121
7	1,110	1,072	1,027	596	631	244	213	592	908	1,019	1,172	1,185	1,077	845	682	234	338	194	316	529	209
8	876	898	894	535	446	201	217	537	1,004	1,176	1,338	1,351	1,261	969	650	230	303	211	372	627	426
9	1,318	1,289	1,072	655	566	282	229	818	1,454	1,343	1,460	1,371	1,186	1,016	803	289	388	237	291	467	244
10	1,010	974	921	527	376	174	184	610	1,241	1,137	1,301	1,290	1,220	1,082	977	361	461	236	425	550	198
11	1,141	1,196	1,090	616	340	134	144	531	1,174	1,396	1,382	1,429	1,398	1,179	883	341	435	242	342	539	267
12	1,634	1,389	1,194	629	443	261	263	1,095	2,432	2,117	2,178	1,731	1,419	1,197	794	253	329	190	253	351	459
13	1,218	942	773	540	472	304	328	1,233	2,261	1,911	1,664	1,373	1,161	847	636	218	236	131	187	314	94
14	901	875	747	439	298	155	167	664	1,546	1,389	1,306	1,205	979	891	676	235	366	186	306	422	159
15	957	836	719	494	346	181	149	596	1,284	1,236	1,283	1,237	1,096	855	754	288	386	261	387	704	314
16	942	849	789	545	409	206	211	795	1,389	1,163	1,257	1,184	996	808	612	190	313	172	295	517	229
17	763	781	708	444	290	284	301	686	1,053	1,005	991	920	980	740	501	179	281	182	258	375	234
18	324	336	321	198	2,841	1,441	1,127	1,280	1,609	1,110	816	712	601	468	261	80	103	75	96	209	175
19	1,061	915	802	515	835	445	411	815	1,218	974	956	979	814	851	461	140	251	144	184	350	249
20	1,010	1,106	1,078	527	430	211	199	573	960	946	1,039	1,097	854	641	545	177	308	239	327	497	224
21	848	863	735	457	1,726	842	711	1,285	1,380	1,028	919	865	730	555	420	133	190	129	228	340	216
22	797	726	710	469	380	285	286	867	1,500	1,311	1,338	1,333	1,123	908	672	230	328	227	306	424	106
23	1,026	947	926	512	294	163	187	1,051	1,982	1,574	1,484	1,402	1,371	1,222	913	285	410	205	305	548	239
24	960	714	686	418	307	163	203	691	1,546	1,412	1,262	1,307	1,156	941	652	224	282	215	307	541	234
25	358	578	579	387	745	400	393	1,069	1,684	1,182	1,091	1,116	1,140	1,095	810	235	337	183	296	587	403
26	1,258	1,609	850	580	443	265	269	1,033	1,810	1,511	1,410	1,229	1,042	814	647	253	322	210	335	484	229
27	1,077	930	916	493	465	312	352	1,227	2,196	1,835	1,801	1,451	1,153	853	539	157	241	127	196	306	139
28	1,687	1,383	1,097	632	489	326	406	1,679	3,087	2,336	1,904	1,556	1,257	1,022	704	233	305	159	181	284	119
29	1,659	1,571	1,549	787	421	192	156	610	1,830	2,202	2,256	2,021	1,724	1,479	987	268	387	193	231	289	108
30	1,156	1,011	900	536	459	262	247	865	1,571	1,323	1,263	1,144	1,001	814	620	184	279	183	252	343	172
31	1,564	1,294	1,159	639	436	265	308	1,513	2,901	2,325	2,000	1,716	1,516	1,228	755	256	295	157	193	268	103
32	1,115	999	978	605	367	187	212	1,029	2,237	1,834	1,744	1,564	1,578	1,319	950	275	407	238	340	560	146
33	747	865	1,031	627	262	65	80	285	633	786	1,029	1,340	1,487	1,435	927	296	441	248	371	662	414
34	848	936	899	479	164	54	76	301	831	948	1,096	1,202	1,290	1,165	928	272	399	287	405	695	615
35	1,616	1,421	1,304	751	343	146	157	619	1,622	1,901	2,088	2,072	1,825	1,514	1,024	369	472	252	423	569	135
Sum	37,813	35,724	33,232	16,678	18,653	9,865	9,390	28,490	52,492	47,895	48,048	45,451	40,889	34,165	24,968	8,395	11,719	7,026	10,256	16,116	569,891

Source: Metropolitan Planning Commission, 2002
* Metropolitan Council District (1991-2002)

Data Table 11. 2000 Census Population by Age, Gender, and Council District (2003 forward), Nashville, TN
2000 Census Data, Table 11-1

Council District	White Male																				Sum				
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84		85+			
1	186	209	210	175	93	37	27	89	193	223	252	307	307	307	301	214	84	129	39	102	153	102	52	40	3,544
2	56	81	61	46	31	10	12	43	91	98	72	93	106	83	87	63	15	31	22	43	50	34	19	11	1,129
3	166	168	160	95	69	32	35	96	184	195	235	257	261	255	233	89	109	57	107	152	101	74	37	3,167	
4	256	235	256	155	250	102	83	237	391	345	403	389	393	335	240	107	145	81	108	210	223	116	92	5,152	
5	164	185	155	88	238	60	44	103	168	207	208	214	186	174	117	46	60	34	42	69	31	18	14	2,625	
6	204	185	164	90	102	48	34	176	425	526	598	491	416	324	203	70	79	47	61	83	64	38	19	4,447	
7	226	240	223	117	91	65	53	133	260	305	353	354	324	264	180	86	111	69	96	178	173	110	55	4,066	
8	280	279	283	167	139	63	58	152	280	386	484	444	483	373	276	81	111	63	134	196	180	83	76	5,071	
9	395	371	351	214	200	79	66	245	428	453	479	446	397	341	270	100	133	97	113	143	107	70	69	5,567	
10	402	339	373	190	211	95	94	278	572	464	521	528	457	434	366	121	193	106	165	223	157	93	51	6,433	
11	449	451	458	222	132	51	66	221	441	561	659	560	537	454	339	139	183	99	151	229	172	113	146	6,833	
12	524	447	387	254	149	82	67	302	693	681	724	646	485	414	293	83	133	70	73	104	70	27	13	6,721	
13	410	275	265	130	134	77	100	351	751	676	589	502	449	320	226	99	82	41	52	117	100	48	23	5,817	
14	395	362	324	194	159	88	93	389	886	752	702	627	526	447	306	127	177	71	142	211	119	64	41	7,202	
15	412	369	287	194	142	70	62	241	549	540	580	537	514	374	324	122	153	108	160	299	230	124	59	6,450	
16	308	314	314	208	164	84	103	317	602	469	544	541	418	372	251	92	137	76	124	210	147	79	53	5,937	
17	110	93	113	83	119	80	71	183	252	261	241	227	222	160	111	40	44	26	38	63	50	41	33	2,661	
18	172	157	159	101	938	455	498	607	765	572	429	407	370	298	152	34	50	24	41	71	80	36	37	6,453	
19	41	18	23	23	116	228	50	170	318	217	185	157	124	119	77	30	25	9	15	18	13	8	1	1,985	
20	326	307	284	182	150	120	124	356	608	603	589	604	549	398	308	97	146	96	121	169	112	67	26	6,342	
21	32	14	10	8	25	19	42	193	269	162	129	75	85	59	42	13	26	11	17	27	27	18	22	1,325	
22	386	320	281	194	122	64	68	301	713	566	486	470	479	421	343	88	158	71	147	173	159	119	64	6,193	
23	478	466	501	220	105	41	36	241	502	472	556	595	639	530	449	111	176	99	158	339	291	157	83	7,245	
24	365	259	268	158	112	58	92	298	784	728	595	591	545	463	314	101	130	91	133	236	184	126	85	6,716	
25	299	264	290	226	309	173	165	437	696	567	473	524	536	535	333	109	145	73	126	205	207	169	167	7,028	
26	353	314	327	173	136	58	55	223	488	519	492	468	489	378	278	103	129	91	142	237	187	129	63	5,832	
27	350	309	298	144	149	66	78	374	826	630	493	416	380	287	182	49	107	71	92	146	106	55	38	5,646	
28	328	278	253	144	104	69	93	270	519	526	569	410	363	273	237	66	100	61	47	76	30	26	13	4,855	
29	327	284	304	178	98	62	51	239	537	558	515	458	395	412	316	99	137	61	82	114	57	35	10	5,329	
30	319	301	264	192	126	77	84	266	500	448	475	432	393	300	272	76	108	88	111	135	99	33	16	5,115	
31	451	336	343	214	108	51	57	231	608	658	635	570	565	542	378	125	128	80	93	134	79	37	23	6,446	
32	367	252	212	102	107	61	89	406	854	723	526	408	346	256	187	48	81	49	50	62	38	25	14	5,263	
33	322	286	237	134	86	59	67	358	796	627	521	431	353	319	200	60	80	35	50	76	35	24	17	5,173	
34	407	504	566	308	126	36	44	139	337	404	490	665	775	778	542	171	249	148	221	336	315	193	124	7,878	
35	620	560	478	264	135	43	44	158	433	635	768	723	649	526	354	121	148	81	116	151	74	43	20	7,144	
Sum	10,886	9,832	9,482	5,587	5,475	2,863	2,805	8,825	17,686	16,731	16,601	15,580	14,493	12,323	8,976	3,002	4,133	2,365	3,473	5,395	4,153	2,469	1,655	184,790	

Data Table 11. 2000 Census Population by Age, Gender, and Council District (2003 forward), Nashville, TN
2000 Census Data, Table 11-2

Council District	White Female																							Sum	
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-64	67-69	70-74	75-79	80-84	85+			
1	176	178	190	137	62	30	34	106	228	276	318	367	318	280	214	72	113	80	119	176	159	108	159	3,898	
2	57	51	51	30	25	10	21	39	78	72	98	90	81	86	92	73	29	43	55	77	72	54	41	1,273	
3	172	168	180	118	51	22	36	89	167	191	245	277	290	235	236	99	104	65	132	207	138	106	93	3,421	
4	253	233	246	164	120	75	60	222	362	360	377	427	411	339	299	145	184	131	211	388	392	302	371	6,072	
5	148	183	143	71	75	29	38	91	148	213	198	197	164	153	128	39	62	50	53	98	53	53	38	2,425	
6	198	154	194	105	71	62	28	127	399	392	383	329	306	247	232	71	86	58	95	150	132	88	83	3,990	
7	193	222	202	118	89	37	50	158	252	282	325	332	332	259	254	90	135	79	145	289	266	177	149	4,435	
8	245	251	241	146	111	54	41	165	294	370	406	475	440	347	272	80	137	120	162	310	267	198	169	5,301	
9	357	345	314	180	146	82	64	231	420	390	462	484	421	392	354	130	181	105	131	238	244	148	134	5,953	
10	384	353	328	178	151	81	78	280	536	486	550	521	522	471	451	187	218	127	218	288	228	155	142	6,933	
11	430	468	401	253	136	52	45	193	487	553	652	587	524	527	420	166	215	135	176	320	348	319	464	7,871	
12	527	436	381	204	155	88	83	354	765	700	734	631	546	471	311	87	118	72	105	140	94	48	36	7,086	
13	316	257	237	136	117	74	68	310	630	583	552	492	440	387	282	79	111	60	103	168	153	75	40	5,670	
14	415	351	329	190	135	92	107	434	822	706	680	619	508	494	408	137	198	122	195	230	195	114	128	7,609	
15	354	331	317	218	117	48	55	191	447	493	545	548	483	409	392	148	210	146	219	384	343	199	206	6,803	
16	306	266	263	182	150	80	71	281	488	440	522	478	436	377	324	106	185	96	208	362	294	196	157	6,268	
17	101	87	67	64	177	96	88	147	213	185	190	166	159	129	111	35	74	39	70	153	154	126	191	2,822	
18	144	157	140	108	1252	584	583	600	771	512	364	357	334	244	126	43	41	46	49	108	142	113	172	6,990	
19	27	44	18	15	181	171	42	159	178	123	88	94	71	91	62	18	27	10	16	16	23	13	8	1,495	
20	293	307	280	189	120	87	92	229	396	333	424	466	410	387	289	107	148	118	166	222	185	115	86	5,449	
21	32	12	14	5	17	25	33	173	204	107	73	67	59	54	44	8	21	14	42	45	52	41	64	1,206	
22	347	323	311	204	94	63	86	392	768	625	566	627	588	573	435	159	204	121	190	328	308	201	156	7,669	
23	403	423	453	253	103	48	55	297	507	481	625	676	651	587	436	126	202	123	195	458	362	234	200	7,898	
24	337	286	253	159	116	67	84	351	787	702	621	588	605	505	388	138	176	124	189	330	344	290	299	7,739	
25	295	295	321	201	404	212	221	570	879	601	542	605	667	539	435	123	196	99	173	357	416	373	458	8,982	
26	361	246	261	188	114	52	61	211	426	426	531	476	460	406	309	140	183	114	205	357	289	206	195	6,217	
27	323	271	252	175	120	79	93	491	881	594	552	438	425	367	291	81	154	82	167	242	179	112	166	6,535	
28	302	281	294	129	99	56	57	234	508	493	413	408	394	315	235	73	122	43	78	98	67	44	31	4,304	
29	299	239	255	201	106	58	50	228	501	488	477	468	440	375	349	108	153	85	101	125	113	64	32	5,404	
30	314	283	253	160	130	74	70	250	414	392	423	419	399	352	299	105	161	97	130	182	103	64	50	4,124	
31	444	400	348	217	94	60	48	285	687	692	673	664	621	581	410	115	165	77	97	142	106	63	33	7,022	
32	322	231	209	88	115	71	95	484	857	561	479	393	371	304	213	70	82	43	65	81	83	40	22	5,279	
33	326	257	239	101	104	69	105	413	704	602	494	479	403	345	220	72	89	48	56	104	91	62	74	5,457	
34	384	514	528	342	114	33	32	138	365	446	582	776	848	806	538	188	254	182	221	392	403	278	279	8,643	
35	500	531	510	262	121	37	45	185	483	694	823	820	711	545	350	132	141	87	122	155	95	71	40	7,550	
Sum	10,175	9,432	8,933	5,484	5,292	2,858	2,819	9,128	17,045	17,403	15,470	15,987	18,842	14,783	13,085	10,150	3,506	4,873	3,024	4,659	7,720	6,893	4,829	4,966	196,993

Data Table 11. 2000 Census Population by Age, Gender, and Council District (2003 forward), Nashville, TN
2000 Census Data, Table 11-3

Council District	Black Male																							Sum
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+	
1	180	258	310	288	143	55	51	143	200	186	229	261	290	320	275	101	138	65	103	116	83	50	45	3,890
2	523	584	534	324	178	83	87	188	337	332	352	360	332	313	231	83	113	76	128	154	97	51	40	5,300
3	387	464	465	235	132	44	66	160	245	248	266	297	258	233	138	43	51	25	36	46	20	17	8	3,884
4	131	146	144	78	58	24	36	98	140	123	146	115	88	76	32	11	11	6	14	13	4	7	4	1,505
5	409	519	520	272	167	54	67	155	258	276	292	326	284	213	143	63	70	43	78	82	41	25	19	4,376
6	450	412	384	214	139	55	55	156	250	286	333	276	190	130	80	19	27	18	26	34	21	11	6	3,572
7	328	303	310	172	91	38	31	98	166	182	223	235	204	157	110	35	47	27	43	58	27	23	10	2,918
8	249	260	247	137	73	27	27	75	141	139	165	170	127	101	55	23	15	9	13	19	11	5	2	2,090
9	135	133	121	68	51	24	14	71	124	131	122	92	74	54	29	5	12	7	4	9	3	5	3	1,291
10	92	107	104	53	36	14	10	39	93	71	79	61	59	47	15	5	12	3	5	7	6	3	1	922
11	48	47	40	20	11	7	7	20	34	37	58	39	34	25	18	7	7	1	4	4	2	4	2	476
12	125	130	133	67	35	12	15	37	100	96	101	73	67	45	23	10	8	3	2	6	3	1	0	1,092
13	115	150	126	61	26	18	17	73	161	158	124	120	75	46	42	14	8	5	5	5	3	0	2	1,354
14	48	62	43	28	18	13	9	41	119	76	81	65	49	40	24	3	7	4	8	4	6	1	2	751
15	66	49	48	41	19	15	11	50	93	90	67	65	38	31	11	3	9	4	1	3	0	0	0	714
16	73	82	62	35	25	16	19	89	143	103	97	89	58	41	16	11	8	5	4	13	9	5	4	1,007
17	515	504	429	251	144	55	41	143	226	234	309	340	353	252	174	65	121	63	79	119	94	54	39	4,604
18	23	21	33	25	44	16	15	35	56	46	39	43	53	35	24	11	17	13	12	20	19	14	7	621
19	455	491	476	247	228	104	89	192	343	315	360	381	353	239	171	50	101	51	80	139	89	62	43	5,059
20	89	77	65	43	89	68	78	217	359	283	267	215	127	73	35	8	9	1	6	8	4	4	0	2,125
21	373	426	407	241	630	271	193	367	301	266	293	329	296	213	191	58	90	70	95	124	111	84	50	5,479
22	21	29	28	7	5	5	5	26	49	28	39	21	19	29	9	1	8	0	2	7	2	0	0	340
23	30	39	25	6	5	9	6	38	49	28	23	23	5	13	8	0	4	1	1	1	5	1	0	320
24	97	76	52	52	11	16	12	47	72	52	53	47	28	19	21	10	9	5	13	6	3	4	0	705
25	5	12	12	20	7	4	1	10	20	15	11	23	9	15	12	4	7	4	7	5	4	4	0	211
26	141	119	120	73	34	34	15	84	130	118	141	149	94	56	47	6	5	3	4	8	4	2	1	1,388
27	92	76	66	36	27	28	21	75	105	115	89	68	53	37	22	4	4	3	3	6	5	3	3	941
28	157	132	134	79	106	81	80	201	344	306	329	253	165	83	25	11	9	6	3	3	4	3	2	2,513
29	178	187	191	98	61	31	19	75	184	158	175	172	142	116	55	14	19	6	7	10	6	6	5	1,915
30	177	192	154	74	64	35	29	142	252	192	179	135	116	77	37	5	14	7	8	9	9	2	2	1,911
31	111	128	146	57	24	14	13	35	73	80	85	88	88	67	32	5	11	1	5	8	6	2	2	1,081
32	154	139	122	74	44	32	25	115	223	210	183	127	98	62	23	7	11	4	3	7	7	0	1	1,671
33	221	219	187	87	47	21	22	96	284	243	208	196	121	70	57	10	11	3	3	8	4	4	4	2,106
34	4	6	5	1	2	1	0	1	3	1	6	3	9	6	7	2	1	1	3	2	1	1	0	66
35	15	14	36	15	7	3	3	4	15	17	23	30	30	27	12	3	2	0	2	2	0	0	0	260
Sum	6,217	6,593	6,279	3,579	2,781	1,327	1,189	3,396	5,692	5,241	5,547	5,287	4,386	3,361	2,184	710	996	543	810	1,066	712	457	305	68,658

Data Table 11. 2000 Census Population by Age, Gender, and Council District (2003 forward), Nashville, TN
2000 Census Data, Table 11-4

Council District	Black Female																							Sum	
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74	75-79	80-84	85+		
1	199	258	289	189	103	56	55	146	255	230	329	337	415	448	348	123	159	94	125	167	126	101	169	4,721	
2	522	520	552	315	194	98	88	278	434	447	573	533	492	400	332	102	188	115	153	233	193	112	136	7,010	
3	373	428	395	258	136	71	57	225	368	378	420	432	379	312	174	51	75	37	52	55	32	23	35	4,766	
4	102	141	127	60	50	36	48	108	178	163	172	143	123	104	47	13	32	7	13	19	20	11	9	1,726	
5	391	587	508	279	165	69	61	180	323	361	453	432	323	257	182	66	108	70	67	137	98	58	50	5,225	
6	474	409	359	182	137	73	102	191	329	261	326	296	213	136	99	28	56	42	37	36	35	26	23	3,870	
7	280	285	278	165	135	58	68	175	208	245	297	300	263	184	131	47	77	41	52	67	40	38	31	3,465	
8	217	273	205	138	66	38	45	133	215	218	244	242	188	124	67	23	26	17	21	23	20	14	5	2,582	
9	162	137	104	74	68	23	19	85	163	137	162	136	103	84	46	13	22	15	11	20	14	14	13	1,625	
10	102	118	101	51	23	18	10	68	131	107	97	81	95	48	27	11	14	9	7	17	12	6	6	1,159	
11	34	55	33	20	7	1	6	25	48	53	50	51	43	41	24	11	10	1	3	8	9	8	9	550	
12	114	138	128	51	36	13	11	59	138	115	141	87	81	58	20	8	5	6	3	6	6	6	0	1,230	
13	134	155	119	63	35	21	19	96	222	161	161	121	86	48	48	10	9	5	9	8	11	2	1	1,544	
14	48	64	43	20	16	14	10	47	89	62	72	63	44	39	12	4	7	7	6	4	6	3	1	681	
15	54	59	39	24	19	9	8	29	77	66	76	55	35	33	11	3	8	3	0	5	2	3	2	620	
16	79	72	95	46	25	15	25	94	160	121	107	107	76	50	23	6	7	7	7	13	16	9	13	1,173	
17	464	453	447	246	172	98	105	242	390	339	405	418	335	287	220	73	132	106	119	199	155	159	145	5,709	
18	19	27	25	19	100	41	46	40	43	38	41	51	49	45	30	16	31	13	23	40	36	23	35	831	
19	441	482	442	238	359	198	141	309	408	422	392	451	343	273	227	73	136	105	118	206	152	100	103	6,119	
20	67	69	51	28	20	26	31	77	109	103	81	68	43	32	20	6	6	6	6	4	5	5	4	867	
21	380	373	384	222	1016	501	380	397	356	324	381	375	343	260	190	72	101	95	142	230	218	142	133	7,015	
22	29	23	19	16	11	6	7	37	52	45	25	34	27	31	21	4	4	4	3	3	4	2	0	407	
23	21	28	36	13	8	2	10	25	44	49	32	19	18	9	2	1	3	4	4	4	1	3	3	319	
24	98	60	45	27	28	21	31	89	110	44	62	67	45	31	34	10	16	13	14	18	16	2	4	885	
25	4	15	11	5	23	3	6	15	17	18	13	21	16	17	16	10	9	6	10	5	14	0	8	272	
26	117	119	105	62	53	18	21	105	180	133	156	134	102	66	43	11	9	1	6	12	6	3	3	1,465	
27	75	96	64	34	31	18	19	94	141	126	95	98	85	43	22	7	12	6	10	19	9	13	16	1,133	
28	153	142	125	73	56	28	32	126	214	195	244	185	139	56	29	9	8	10	8	8	3	6	3	1,859	
29	153	144	206	80	54	23	14	174	193	216	237	202	188	119	71	71	12	13	13	15	8	6	2,136		
30	149	158	151	68	69	37	55	149	244	179	188	187	188	111	77	34	17	9	16	13	6	7	3	1,936	
31	105	144	113	62	34	23	16	49	125	94	115	119	107	66	24	12	12	5	5	8	3	3	6	1,250	
32	136	147	120	70	40	21	24	160	339	211	198	172	146	60	31	10	14	2	9	12	12	4	3	1,941	
33	220	233	212	109	47	21	37	179	337	327	279	216	173	73	31	6	10	9	11	12	8	5	5	2,560	
34	3	5	14	5	1	0	1	1	2	3	6	8	10	11	9	5	3	1	2	2	5	4	0	101	
35	19	20	21	17	6	6	3	10	24	16	33	34	26	25	25	10	2	4	3	0	2	4	1	0	286
Sum	5,936	6,467	5,966	3,329	3,343	1,608	1,616	4,157	6,066	5,987	6,663	6,275	5,263	3,947	2,675	874	1,434	887	1,085	1,627	1,306	932	983	79,038	

Data Table 11. 2000 Census Population by Age, Gender, and Council District (2003 forward), Nashville, TN
2000 Census Data, Table 11-5

Council District	Male Total																			Sum
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	
1	382	454	527	476	244	94	80	240	406	421	495	578	612	627	497	189	270	126	206	7,604
2	619	709	624	385	223	104	110	276	429	434	474	484	428	407	300	102	148	100	172	6,991
3	576	648	642	331	206	77	101	262	438	450	508	560	529	497	373	133	163	82	145	7,186
4	438	413	434	258	346	147	142	386	618	514	598	538	518	438	293	123	159	88	123	7,255
5	637	767	721	880	436	129	119	295	486	538	535	580	486	409	265	111	135	77	124	7,538
6	727	654	595	336	265	115	106	373	754	863	980	811	642	477	296	90	108	66	88	8,631
7	603	583	566	305	192	109	89	241	455	513	597	613	544	433	301	122	161	100	140	7,309
8	572	581	556	321	224	97	93	244	449	555	685	633	630	490	339	107	129	72	149	7,505
9	608	557	498	312	287	115	101	377	654	640	638	577	495	413	306	107	148	105	119	7,469
10	535	477	515	269	258	115	117	352	704	568	638	617	536	494	399	129	208	111	171	7,761
11	524	531	520	256	149	60	77	247	500	633	736	614	588	490	365	148	192	105	157	7,568
12	726	634	548	338	198	100	91	371	864	842	864	746	571	476	330	94	144	73	80	8,315
13	659	506	453	272	230	151	173	607	1,211	1,060	865	732	591	406	298	125	99	50	58	8,847
14	499	469	389	242	189	109	111	450	1,072	893	815	716	597	504	336	136	189	77	151	8,397
15	590	485	390	307	251	131	111	457	879	800	756	680	617	451	353	130	166	113	162	8,548
16	538	488	465	301	258	142	171	582	1,006	754	775	721	547	464	304	109	154	89	135	8,544
17	692	638	569	351	285	145	123	356	526	539	581	584	589	433	293	111	168	94	119	7,696
18	231	218	217	135	1,117	533	569	746	934	706	530	494	435	343	184	46	72	38	55	7,894
19	536	542	507	287	382	352	152	398	740	593	589	563	491	367	256	81	127	62	97	7,503
20	513	467	403	274	288	209	231	678	1,129	1,011	949	890	720	519	380	122	172	106	134	9,594
21	421	449	429	257	661	294	294	585	629	456	442	415	390	276	233	73	118	85	116	7,038
22	454	392	357	220	134	70	76	351	828	661	584	527	532	467	367	98	171	74	157	7,063
23	531	535	547	240	115	51	43	293	591	544	608	639	661	554	471	116	188	106	161	7,882
24	518	355	340	229	142	79	114	382	943	852	692	672	592	507	351	116	144	99	148	7,930
25	325	289	312	251	334	187	177	478	763	618	516	561	559	563	352	114	153	79	123	7,531
26	822	529	550	255	228	121	95	399	773	783	713	686	634	484	347	125	143	100	149	8,447
27	554	479	435	226	221	119	118	528	1,111	865	682	539	477	357	218	59	115	74	98	7,648
28	615	501	442	261	227	170	196	535	963	951	982	728	576	392	286	78	116	74	54	8,306
29	595	538	543	295	176	101	80	360	811	782	739	676	563	550	387	119	162	68	91	7,886
30	666	613	501	335	249	151	150	547	990	795	782	643	566	411	329	85	128	101	124	8,483
31	628	518	526	301	148	72	81	289	734	797	780	697	691	635	432	133	146	85	98	8,093
32	621	456	377	196	169	105	129	573	1,172	1,020	778	577	475	345	231	59	95	57	76	7,658
33	610	556	449	240	141	90	100	493	1,162	966	786	657	501	417	251	72	100	39	53	7,866
34	424	525	590	317	132	39	45	148	348	412	506	682	805	800	560	179	256	151	228	8,126
35	677	614	552	292	149	47	47	171	470	682	821	788	705	571	372	131	163	82	126	7,753
Sum	19,466	18,200	17,089	10,120	9,254	4,730	4,558	14,070	26,542	24,511	24,019	22,218	19,891	16,467	11,655	3,874	5,310	3,010	4,378	275,865

Source: Metropolitan Planning Commission, 2002
* Metropolitan Council District (2003 forward)

Data Table 11. 2000 Census Population by Age, Gender, and Council District (2003 forward), Nashville, TN
2000 Census Data, Table 11-6

Council District	Female Total																				Sum			
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-61	62-64	65-66	67-69	70-74		75-79	80-84	85+
1	386	446	491	342	167	87	92	262	502	517	664	718	753	740	573	198	273	175	244	349	288	209	329	8,805
2	609	597	630	359	229	109	113	332	538	539	690	638	586	496	413	132	235	148	208	313	267	166	178	8,525
3	566	609	583	385	190	96	96	320	542	576	678	714	681	555	415	153	181	104	186	265	172	131	128	8,326
4	420	411	403	244	192	122	118	364	588	554	575	597	569	470	355	161	219	142	232	412	417	318	385	8,268
5	613	833	685	372	253	101	105	289	516	600	673	653	507	423	319	109	173	121	121	241	157	112	93	8,069
6	758	621	603	311	232	143	141	344	767	681	737	657	545	396	336	102	151	101	139	188	168	114	108	8,343
7	525	538	505	298	238	99	124	341	478	538	647	652	616	452	395	140	214	122	201	360	311	216	182	8,192
8	500	552	468	296	194	99	91	311	527	618	673	740	647	483	367	106	167	140	185	338	290	213	175	8,180
9	582	536	454	275	230	114	92	339	630	561	659	648	545	488	413	147	205	121	150	261	261	167	150	8,028
10	531	511	441	249	182	105	92	362	707	627	669	635	643	540	488	204	236	141	230	308	244	163	148	8,456
11	499	550	451	281	146	56	53	221	565	628	724	664	581	581	452	180	231	138	181	335	359	329	474	8,679
12	715	617	543	286	198	106	102	431	955	861	915	737	645	546	348	100	134	80	110	146	103	54	36	8,718
13	584	526	417	253	189	121	107	495	997	826	801	657	566	462	353	98	128	69	115	179	166	79	42	8,230
14	507	451	392	221	159	108	130	502	966	815	784	711	572	443	430	144	212	130	202	237	304	118	129	8,667
15	502	445	394	267	171	80	82	301	638	631	682	653	559	469	421	155	221	150	220	392	247	209	8,193	
16	527	436	433	279	219	117	122	458	803	668	703	638	571	461	373	116	197	111	223	379	318	213	173	8,538
17	618	575	541	322	365	202	200	408	636	561	609	593	511	434	334	109	210	149	191	361	311	287	340	8,867
18	208	222	181	141	1,473	684	691	706	908	627	454	438	396	296	165	61	76	60	74	150	183	138	208	8,540
19	501	550	478	257	573	376	199	502	653	589	509	570	425	377	302	94	166	116	136	225	176	117	116	8,007
20	444	425	390	260	167	120	130	349	597	513	552	597	497	456	341	123	170	127	178	234	195	123	91	7,079
21	425	396	405	231	1,057	533	424	595	603	459	463	459	410	322	238	81	125	111	188	282	273	190	200	8,470
22	440	400	366	240	115	77	96	448	889	728	638	712	638	625	469	168	220	135	197	336	315	203	157	8,612
23	459	473	507	279	112	51	67	333	589	548	681	725	686	615	451	131	208	131	202	462	369	236	205	8,518
24	473	369	314	196	165	94	123	465	952	797	720	676	679	557	433	154	197	142	208	353	364	295	306	9,032
25	317	322	348	212	441	221	231	605	933	657	573	635	700	569	462	136	208	107	183	365	431	385	472	9,513
26	612	454	464	303	204	90	103	377	704	649	746	674	612	497	376	160	198	123	219	298	210	200	8,647	
27	520	446	374	240	182	113	132	644	1,143	816	709	578	560	432	322	92	171	91	182	267	191	127	163	8,515
28	555	513	388	226	190	102	107	405	820	667	726	637	517	399	283	87	132	53	92	111	71	56	34	7,715
29	521	468	512	309	184	91	74	408	763	766	768	706	653	614	439	121	166	102	118	146	119	53	58	8,139
30	622	535	506	278	243	139	152	473	813	667	694	680	549	469	345	130	181	107	151	203	112	75	53	8,177
31	605	615	509	310	142	87	69	354	873	841	849	820	772	682	454	131	181	88	104	156	111	67	40	8,860
32	526	427	359	176	179	109	138	698	1,289	844	732	601	546	391	253	83	105	47	80	96	97	44	27	7,847
33	614	547	480	222	164	102	152	634	1,147	1,005	818	725	603	443	262	82	103	61	71	123	99	69	81	8,607
34	404	531	564	364	123	34	34	143	375	459	608	803	875	829	559	194	263	183	228	401	412	287	279	8,952
35	659	577	564	294	131	47	50	201	544	751	906	892	783	586	374	139	152	90	129	160	102	73	42	8,226
Sum	18,347	17,524	16,143	9,558	9,399	4,935	4,832	14,420	25,950	23,184	24,029	23,233	20,978	17,686	13,313	4,521	6,409	4,016	5,878	9,508	8,301	5,841	6,009	294,026

Data Table 11. 2000 Census Population by Age, Gender, and Council District (2003 forward), Nashville, TN
2000 Census Data, Table 11-7

Council District	Total																						Sum	
	<5	5-9	10-14	15-17	18-19	20	21	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-			
1	768	930	1,018	818	411	181	172	502	908	938	1,159	1,296	1,365	1,367	1,070	387	543	301	450	623	475	312	415	16,409
2	1,228	1,306	1,254	744	452	213	223	608	967	973	1,164	1,122	1,014	903	713	234	383	248	380	518	402	238	229	15,516
3	1,142	1,257	1,225	716	396	173	197	582	980	1,026	1,186	1,274	1,210	1,052	788	288	344	186	331	468	294	224	173	15,512
4	858	824	837	502	538	269	260	750	1,206	1,068	1,173	1,135	1,087	908	648	284	378	230	355	637	650	441	485	15,523
5	1,250	1,600	1,406	752	689	230	224	584	1,002	1,138	1,208	1,233	993	832	584	220	308	198	245	396	232	156	127	15,607
6	1,485	1,275	1,198	647	497	258	247	717	1,521	1,544	1,717	1,468	1,187	873	632	192	259	167	227	309	257	164	133	16,974
7	1,128	1,121	1,071	603	430	208	213	582	933	1,051	1,244	1,265	1,160	885	696	262	375	222	341	600	512	350	249	15,501
8	1,072	1,133	1,024	617	418	196	184	555	976	1,173	1,358	1,373	1,277	973	706	213	296	212	334	558	482	302	253	15,685
9	1,190	1,093	952	587	517	229	193	716	1,284	1,201	1,297	1,225	1,040	901	719	254	353	226	269	416	371	242	222	15,497
10	1,066	988	956	518	440	220	209	714	1,411	1,195	1,307	1,252	1,179	1,034	887	333	444	252	401	542	410	259	200	16,217
11	1,023	1,081	971	537	295	116	130	468	1,065	1,261	1,460	1,278	1,167	1,071	817	328	423	243	338	571	535	447	622	16,247
12	1,441	1,251	1,091	604	396	206	193	802	1,819	1,703	1,779	1,483	1,216	1,022	678	194	278	153	190	257	176	82	49	17,063
13	1,243	1,032	870	525	419	272	280	1,102	2,208	1,886	1,666	1,389	1,157	868	651	223	227	119	173	303	269	128	67	17,077
14	1,006	920	781	463	348	217	241	952	2,038	1,708	1,599	1,427	1,169	1,047	766	280	401	207	353	452	331	186	172	17,064
15	1,092	930	784	574	422	211	193	758	1,517	1,431	1,438	1,333	1,176	920	774	285	387	263	382	698	577	328	268	16,741
16	1,065	924	898	580	477	259	293	1,040	1,809	1,422	1,478	1,359	1,118	925	677	225	351	200	358	609	484	298	233	17,082
17	1,310	1,213	1,110	673	650	347	323	764	1,162	1,100	1,190	1,177	1,100	867	627	220	378	243	310	548	456	382	413	16,563
18	439	440	398	276	2,590	1,217	1,260	1,452	1,842	1,333	984	932	831	639	349	107	148	98	129	246	282	189	253	16,434
19	1,037	1,092	985	544	955	728	351	900	1,393	1,182	1,098	1,133	916	744	558	175	293	178	233	388	278	187	162	15,510
20	957	892	793	534	455	329	361	1,027	1,726	1,524	1,501	1,487	1,217	975	721	245	342	233	312	418	313	194	117	16,673
21	846	845	834	488	1,718	827	664	1,180	1,232	915	905	874	800	598	471	154	243	196	304	436	411	292	275	15,508
22	894	792	723	460	249	147	172	799	1,717	1,389	1,222	1,239	1,170	1,092	836	266	391	209	354	527	480	323	224	15,675
23	990	1,008	1,054	519	227	102	110	626	1,180	1,092	1,289	1,364	1,347	1,169	922	247	396	237	363	807	666	396	289	16,400
24	991	724	654	424	307	173	237	847	1,895	1,649	1,412	1,348	1,271	1,064	784	270	341	241	356	690	552	431	391	16,982
25	642	611	660	463	775	408	408	1,083	1,696	1,275	1,089	1,196	1,259	1,132	814	250	361	186	316	578	642	560	640	17,044
26	1,234	983	1,014	628	432	211	198	776	1,477	1,432	1,459	1,360	1,246	981	723	285	341	223	368	624	494	341	264	17,094
27	1,074	925	809	466	403	232	250	1,172	2,254	1,681	1,391	1,117	1,037	789	540	151	286	165	280	421	307	188	225	16,163
28	1,170	1,014	830	487	417	272	303	940	1,783	1,618	1,708	1,365	1,093	791	569	165	248	127	146	193	105	84	49	15,477
29	1,116	1,006	1,055	604	360	192	154	768	1,574	1,548	1,507	1,382	1,216	1,164	826	240	328	170	209	277	182	94	53	16,025
30	1,288	1,148	1,007	613	492	290	302	1,020	1,803	1,462	1,476	1,323	1,115	880	674	215	309	208	275	354	221	112	73	16,660
31	1,233	1,133	1,035	611	290	159	150	643	1,607	1,638	1,629	1,517	1,463	1,317	886	264	327	173	202	304	200	107	65	16,953
32	1,147	883	736	372	348	214	267	1,271	2,461	1,864	1,510	1,178	1,021	736	484	142	200	106	137	172	144	69	43	15,505
33	1,224	1,103	929	462	305	192	252	1,127	2,309	1,971	1,604	1,382	1,104	860	513	154	203	100	124	211	143	98	103	16,473
34	828	1,056	1,154	681	255	73	79	291	723	871	1,114	1,485	1,680	1,629	1,119	373	519	334	456	742	732	481	403	17,078
35	1,336	1,191	1,116	586	280	94	97	372	1,014	1,433	1,727	1,680	1,468	1,157	746	270	315	172	255	313	177	117	63	15,979
Sum	37,813	35,724	33,232	19,678	18,653	9,665	9,392	28,490	52,492	47,695	48,048	45,451	40,869	34,165	24,968	8,395	11,719	7,026	10,256	16,116	13,242	8,802	8,002	569,891

Source: Metropolitan Planning Commission, 2002
*Metropolitan Council District (2003 forward)

Data Table 12. Population by Race, Ethnicity, Gender, and Council District (2003 forward), Nashville, TN, 2000

Council District	2000 Population Total			Black or African American			White			Other Races*			* Other Races in Detail												Hispanic Alone					
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	American Indian/Alaska			Asian			Hawaiian/Pacific Islander			Two or More Races						Some Other Race		
1	7,604	8,805	16,409	3,890	4,721	8,611	3,544	3,898	7,442	170	186	356	26	24	50	28	37	65	1	2	3	85	103	188	30	20	50	63	56	119
2	6,991	8,525	15,516	5,500	7,010	12,510	1,129	1,273	2,402	362	242	604	21	21	42	60	58	118	10	8	18	110	98	208	161	57	218	232	89	321
3	7,186	8,326	15,512	3,884	4,766	8,650	3,167	3,421	6,588	135	139	274	17	12	29	21	34	55	0	0	0	73	73	146	24	20	44	46	30	76
4	7,255	8,268	15,523	1,505	1,726	3,231	5,152	6,072	11,224	598	470	1,068	35	22	57	97	115	212	14	6	20	156	150	306	296	177	473	450	280	730
5	7,538	8,069	15,607	4,376	5,225	9,601	2,625	2,425	5,050	537	419	956	29	19	48	44	35	79	3	1	4	185	168	353	276	196	472	491	365	856
6	8,631	8,343	16,974	3,572	3,870	7,442	4,447	3,990	8,437	612	483	1,095	48	30	78	102	87	189	18	37	55	270	224	494	174	105	279	349	160	509
7	7,309	8,192	15,501	2,918	3,465	6,383	4,066	4,435	8,501	325	292	617	31	25	56	73	69	142	1	1	2	122	136	258	98	61	159	182	113	295
8	7,505	8,180	15,685	2,090	2,582	4,672	5,071	5,301	10,372	344	297	641	33	27	60	80	78	158	1	0	1	133	119	252	97	73	170	194	126	320
9	7,469	8,028	15,497	1,291	1,625	2,916	5,567	5,953	11,520	611	450	1,061	37	32	69	48	64	112	5	6	11	172	149	321	349	199	548	654	378	1,032
10	7,761	8,456	16,217	922	1,159	2,081	6,433	6,933	13,366	406	364	770	25	25	50	75	100	175	2	1	3	114	119	233	190	119	309	337	208	545
11	7,568	8,679	16,247	476	550	1,026	6,833	7,871	14,704	259	258	517	25	30	55	64	85	149	0	1	1	86	86	172	84	56	140	196	141	337
12	8,315	8,748	17,063	1,092	1,230	2,322	6,721	7,086	13,807	502	432	934	28	38	66	143	146	289	4	3	7	171	127	298	156	118	274	301	232	533
13	8,847	8,230	17,077	1,354	1,544	2,898	5,817	5,670	11,487	1,676	1,016	2,692	36	39	75	265	240	505	29	18	47	311	238	549	1,035	481	1,516	1,708	825	2,533
14	8,397	8,667	17,064	751	681	1,432	7,202	7,609	14,811	444	377	821	47	33	80	96	107	203	3	4	7	113	99	212	185	134	319	415	299	714
15	8,548	8,193	16,741	714	620	1,334	6,450	6,803	13,253	1,384	770	2,154	42	24	66	111	133	244	4	0	4	320	240	560	907	373	1,280	1,424	680	2,104
16	8,544	8,538	17,082	1,007	1,173	2,180	5,937	6,268	12,205	1,600	1,097	2,697	32	25	57	428	375	803	14	8	22	309	249	558	817	440	1,257	1,313	714	2,027
17	7,696	8,867	16,563	4,604	5,709	10,313	2,661	2,822	5,483	431	336	767	11	21	32	112	115	227	5	13	18	139	112	251	164	75	239	318	184	502
18	7,894	8,540	16,434	621	831	1,452	6,453	6,990	13,443	820	719	1,539	24	9	33	572	517	1,089	10	9	19	154	121	275	60	63	123	212	195	407
19	7,503	8,007	15,510	5,059	6,119	11,178	1,985	1,495	3,480	459	393	852	22	10	32	188	189	377	6	2	8	143	140	283	100	52	152	206	140	346
20	9,594	7,079	16,673	2,125	867	2,992	6,342	5,449	11,791	1,127	763	1,890	46	33	79	454	388	842	6	6	12	238	178	416	383	158	541	701	332	1,033
21	7,038	8,470	15,508	5,479	7,015	12,494	1,325	1,206	2,531	234	249	483	12	16	28	106	107	213	3	5	8	88	103	191	25	18	43	71	68	139
22	7,063	8,612	15,675	340	407	747	6,193	7,669	13,862	530	536	1,066	20	9	29	278	311	589	2	2	4	163	142	305	67	72	139	172	185	357
23	7,882	8,518	16,400	320	319	639	7,245	7,898	15,143	317	301	618	12	7	19	188	170	358	1	2	3	87	94	181	29	28	57	100	107	207
24	7,930	9,032	16,962	705	885	1,590	6,716	7,739	14,455	509	408	917	25	23	48	228	188	416	2	7	9	161	141	302	93	49	142	217	159	376
25	7,531	9,513	17,044	211	272	483	7,028	8,982	16,010	292	259	551	14	15	29	180	155	335	12	6	18	64	66	130	22	17	39	84	96	180
26	8,447	8,647	17,094	1,388	1,465	2,853	5,832	6,217	12,049	1,227	965	2,192	25	17	42	351	347	698	7	5	12	311	299	610	533	297	830	943	589	1,532
27	7,648	8,515	16,163	941	1,133	2,074	5,646	6,535	12,181	1,061	847	1,908	20	16	36	269	224	493	7	9	16	345	313	658	420	285	705	715	479	1,194
28	8,306	7,171	15,477	2,513	1,859	4,372	4,855	4,504	9,359	938	808	1,746	38	18	56	339	341	680	7	5	12	209	181	390	345	263	608	839	603	1,442
29	7,886	8,139	16,025	1,915	2,136	4,051	5,329	5,404	10,733	642	599	1,241	21	27	48	244	257	501	8	6	14	153	142	295	216	167	383	383	330	713
30	8,483	8,177	16,660	1,911	1,936	3,847	5,115	5,124	10,239	1,457	1,117	2,574	24	20	44	273	240	513	2	4	6	342	302	644	816	551	1,367	1,396	949	2,345
31	8,093	8,860	16,953	1,081	1,250	2,331	6,446	7,022	13,468	566	588	1,154	12	17	29	290	333	623	4	4	8	137	130	267	123	104	227	280	215	495
32	7,658	7,847	15,505	1,671	1,941	3,612	5,263	5,279	10,542	724	627	1,351	21	25	46	276	276	552	6	4	10	200	178	378	221	144	365	457	376	833
33	7,866	8,607	16,473	2,106	2,560	4,666	5,173	5,457	10,630	587	590	1,177	21	23	44	278	306	584	4	10	14	158	147	305	126	104	230	285	255	540
34	8,126	8,952	17,078	66	101	167	7,878	8,643	16,521	182	208	390	13	10	23	97	106	203	0	2	2	52	64	116	20	26	46	73	71	144
35	7,753	8,226	15,979	260	286	546	7,144	7,550	14,694	349	390	739	21	23	44	235	249	484	1	4	5	60	74	134	32	40	72	126	129	255
Total	275,865	294,026	569,891	68,658	79,038	147,696	184,790	196,993	381,783	22,417	17,995	40,412	914	765	1,679	6,693	6,582	13,275	202	201	403	5,934	5,305	11,239	8,674	5,142	13,816	15,933	10,158	26,091

Source: Metropolitan Planning Commission, 2002

* Metropolitan Council District (2003 forward)

Data Table 13. Percentage of Population's Educational Attainment, Persons 25 Years and Over, Nashville, Tennessee, and the United States, 1990 and 2000

	Nashville		TN		U.S.	
	1990	2000	1990	2000	1990	2000
Less than high school diploma	24.1	18.4	32.9	24.1	24.8	19.6
High school graduate	26.9	24.6	30.0	31.6	30.0	28.6
Some college	19.7	21.5	16.9	20.0	18.7	21.0
Associate degree	4.9	4.9	4.2	4.7	6.2	6.3
Bachelor's degree and higher	24.4	30.5	16.0	19.6	20.3	24.4

Source: U.S. Census Bureau, Census 1990 and 2000, Table DP-2: Profile of Selected Social Characteristics.

Data Table 14. Percentage of Persons Below Poverty Level*, Nashville, TN, 1990 and 2000

Nashville	1990	2000
All Ages	13.0	13.0
Children Under 18 Years	19.4	19.1
Children 5-17 Years	18.3	18.0
Person 65 Years and Over	14.5	10.5

Source: U.S. Census Bureau, (1) Census 1990: DP-4: Income and Poverty Status in 1989-1990,

(2) Census 2000 Table DP-3: Profile of Selected Economic Characteristics.

* Poverty status in 1989 and 1999 respectively.

Data Table 15. Percentage of Persons Below Poverty Level*, Nashville, Tennessee, and the United States, 2000

	Nashville	TN	U.S.
All Ages	13.0	13.5	12.4
Children Under 18 Years	19.1	17.6	16.1
Children 5-17 Years	18.0	16.6	15.4
Person 65 Years and Over	10.5	13.5	9.9
Single Female Householder **	27.3	29.5	26.5
Single Female Householder with Children under 18 Years	34.7	37.6	34.3
Single Female Householder with Children under 5 Years	48.4	50.2	46.4

Source: U.S. Census Bureau, Census 2000 Table DP-3: Profile of Selected Economic Characteristics.

* Poverty status in 1999

**Families with female householder, no husband present.

Data Table 16. Per Capita Income and Median Household Income, Current Dollar and 2000 Adjusted Dollar, Nashville, TN 1990 to 2000

	Current Dollar		2000 Dollar	
	Per Capita	Median Household	Per Capita	Median Household
1990	19,700.00	29,550.00	25,955.00	38,933.00
1991	20,722.00	30,050.00	26,199.00	37,993.00
1992	22,448.00	30,350.00	27,552.00	37,251.00
1993	23,655.00	30,796.00	28,190.00	36,699.00
1994	26,411.00	32,700.00	30,688.00	37,996.00
1995	28,355.00	34,200.00	32,039.00	38,643.00
1996	29,815.00	35,500.00	32,722.00	38,962.00
1997	31,345.00	36,300.00	33,630.00	38,946.00
1998	32,827.00	37,541.00	34,680.00	39,660.00
1999	34,290.00	39,568.00	35,443.00	40,898.00
2000	35,797.00	37,890.00	35,797.00	37,890.00

Source: Nashville Area Chamber of Commerce, 2002

Inflation adjustment is done by <http://www.aler.org/cgi-bin/calculator.cgi>, accessed on 3/25/2002

Data Table 17. Male or Female Householder, with Own Children Under 18 Years, Nashville, TN, 1990 and 2000

	1990		2000	
	Number	% of Household	Number	% of Household
Total	207,497		237,583	
Male Householder, no wife present	6,095	2.9	11,166	4.7
With own children under 18	2,440	1.2	2,776	1.2
Female Householder, no husband present	29,072	14.0	33,136	13.9
With own children under 18	16,798	8.1	21,735	9.1

Source: 1990 census of population and housing summary tape file 3A and

U.S. Census Bureau The Census 2000 Supplementary Survey, available at <http://fwwww.census.gov>

Data Table 18. Percentage of Families with Female Householder, No Husband Present, Nashville, Tennessee, and the United States, 1990 and 2000

	1990	2000
Nashville	14.2	14.3
Tennessee	12.6	12.9
U.S.	11.6	12.2

Source: U.S. Census Bureau, Profile of General Demographic Characteristics: 2000 and Geographic Comparison Table.

Data Table 19. Responses to BRFSS Questions Regarding Lack of Health Insurance, Nashville, TN, 1996

Question	Response	Total	Gender		Race			Marital Status		Age Group					Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	< HS Diploma	HS Diploma	Some College	College Degree
1996 - Adults age 18 to 64																		
Do you have any kind of health coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, Medicaid, or TennCare?		N*=2386	N*=1143	N*=1243	N*=1789	N*=547	N*=50	N*=1126	N*=1259	N*=388	N*=642	N*=614	N*=448	N*=295	N*=269	N*=745	N*=617	N*=755
	Yes	87.0%	85.1%	88.6%	87.3%	86.2%	84.2%	92.1%	82.4%	75.3%	85.4%	88.0%	92.4%	95.3%	84.9%	81.8%	86.9%	92.9%
	No	12.7%	14.5%	11.1%	12.4%	13.4%	15.8%	7.9%	17.0%	22.8%	14.6%	12.0%	7.7%	4.7%	15.1%	17.3%	13.1%	7.1%
	Don't know	0.3%	0.3%	0.3%	0.3%	0.4%	0.0%	0.0%	0.6%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
About how long has it been since you had health care coverage?		N*=2386	N*=1143	N*=1243	N*=1789	N*=547	N*=50	N*=1126	N*=1259	N*=388	N*=642	N*=614	N*=448	N*=295	N*=269	N*=745	N*=617	N*=755
	Not Asked	90.3%	88.8%	91.8%	90.1%	91.2%	90.8%	95.5%	85.7%	82.7%	88.9%	90.0%	94.8%	97.4%	86.4%	87.4%	90.2%	94.7%
	1 to 6 months ago	2.4%	2.7%	2.1%	2.8%	1.4%	1.3%	1.1%	3.6%	5.4%	2.9%	2.0%	0.9%	0.6%	2.2%	2.9%	2.9%	1.6%
	6 to 12 months ago	1.7%	1.7%	1.6%	1.5%	1.9%	3.1%	0.9%	2.3%	2.6%	1.6%	2.5%	0.7%	0.3%	1.6%	2.8%	1.4%	0.8%
	1 to 2 years ago	1.4%	1.4%	1.4%	1.1%	2.0%	3.6%	0.8%	1.9%	3.0%	1.1%	1.4%	1.1%	0.0%	2.7%	1.4%	2.1%	0.3%
	2 to 5 years ago	1.5%	2.0%	1.0%	1.8%	0.8%	0.0%	0.4%	2.5%	2.8%	2.2%	1.3%	0.6%	0.1%	3.7%	1.7%	0.8%	1.1%
	5 or more years ago	1.1%	1.3%	0.9%	1.2%	0.8%	0.0%	0.4%	1.7%	0.4%	0.8%	1.9%	0.8%	1.5%	2.1%	1.5%	1.0%	0.5%
	Never	1.1%	1.4%	0.9%	1.2%	1.1%	0.0%	0.6%	1.6%	2.3%	1.4%	0.6%	1.1%	0.1%	0.7%	1.6%	1.2%	0.8%
	Don't know	0.5%	0.7%	0.4%	0.4%	0.8%	1.2%	0.3%	0.7%	0.8%	1.2%	0.3%	0.0%	0.0%	0.6%	0.8%	0.3%	0.4%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Planning Districts																		
Question	Response	Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum / Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage			
1996 - Adults age 18 to 64																		
Do you have any kind of health coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, Medicaid, or TennCare?		N*=155	N*=171	N*=155	N*=183	N*=160	N*=173	N*=184	N*=143	N*=152	N*=157	N*=179	N*=192	N*=198	N*=183			
	Yes	89.2%	78.2%	85.4%	95.7%	87.5%	87.6%	90.4%	77.5%	86.6%	92.6%	87.8%	85.1%	81.6%	91.2%			
	No	10.8%	19.4%	14.6%	4.4%	12.5%	12.4%	8.4%	22.5%	13.4%	6.9%	12.2%	14.9%	18.4%	8.8%			
	Don't know	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%			
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
About how long has it been since you had health care coverage?		N*=155	N*=171	N*=155	N*=183	N*=160	N*=173	N*=184	N*=143	N*=152	N*=157	N*=179	N*=192	N*=198	N*=183			
	Not Asked	94.6%	86.1%	91.6%	97.5%	90.3%	91.0%	92.0%	80.4%	88.3%	93.7%	91.2%	84.6%	89.4%	92.9%			
	1 to 6 months ago	1.5%	3.3%	2.3%	0.5%	1.6%	0.9%	2.0%	6.0%	1.6%	0.0%	1.7%	4.7%	5.4%	1.9%			
	6 to 12 months ago	1.5%	2.0%	1.5%	0.9%	1.6%	2.8%	1.7%	3.1%	0.5%	1.5%	2.3%	2.9%	0.9%	0.0%			
	1 to 2 years ago	1.3%	0.0%	0.6%	0.4%	4.8%	1.4%	0.9%	1.8%	0.7%	1.4%	1.8%	3.4%	0.8%	0.0%			
	2 to 5 years ago	0.6%	4.6%	0.5%	0.0%	1.3%	0.0%	0.4%	0.6%	3.8%	1.1%	2.0%	0.0%	1.8%	4.4%			
	5 or more years ago	0.0%	1.4%	0.0%	0.8%	0.0%	2.1%	0.0%	2.6%	2.3%	2.4%	0.9%	2.3%	0.4%	0.5%			
	Never	0.6%	2.5%	0.6%	0.0%	0.4%	1.8%	2.5%	3.8%	2.1%	0.0%	0.0%	1.4%	0.5%	0.0%			
	Don't know	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%	0.5%	1.6%	0.8%	0.0%	0.0%	0.8%	0.8%	0.3%			
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996.

Data Table 20. Responses to BRFSS Questions Regarding Lack of Health Insurance, Nashville, TN, 1998

Data Table for Responses to HHS-24 questions regarding Lack of Health Insurance, Race/ethnicity, 18-64, 1998																		
Question	Response	Total	Gender		Race			Marital Status		Age Group					Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	< HS Diploma	HS Diploma	Some College	College Degree
1998 - Adults age 18 to 64																		
Do you have any kind of health coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?		N*=2753	N*=1316	N*=1437	N*=2051	N*=643	N*=59	N*=1306	N*=1443	N*=438	N*=702	N*=726	N*=549	N*=337	N*=260	N*=827	N*=741	N*=924
	Yes	90.1%	88.8%	91.3%	90.5%	89.1%	88.8%	95.0%	85.7%	86.3%	89.0%	89.2%	93.3%	94.1%	81.0%	87.7%	89.5%	95.3%
	No	9.8%	11.2%	8.6%	9.4%	10.9%	11.2%	5.0%	14.2%	13.4%	11.0%	10.8%	6.7%	5.7%	19.0%	12.1%	10.4%	4.7%
	Don't know	0.1%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.2%	0.4%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%	0.1%	0.0%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
About how long has it been since you had health care coverage?		N*=2753	N*=1316	N*=1437	N*=2051	N*=643	N*=59	N*=1306	N*=1443	N*=438	N*=702	N*=726	N*=549	N*=337	N*=260	N*=827	N*=741	N*=924
	Skipped	90.2%	88.8%	91.4%	90.6%	89.0%	88.8%	95.0%	85.8%	86.7%	89.0%	89.2%	93.3%	94.3%	81.0%	87.9%	89.6%	95.3%
	1 to 6 months ago	2.7%	2.5%	3.0%	2.5%	3.6%	3.2%	1.7%	3.7%	6.3%	3.3%	2.7%	0.2%	1.0%	5.0%	3.5%	3.1%	1.1%
	6 to 12 months ago	1.3%	1.3%	1.3%	1.3%	1.6%	1.1%	0.7%	2.0%	1.0%	1.8%	1.3%	1.5%	0.6%	1.4%	1.8%	1.6%	0.8%
	1 to 2 years ago	1.6%	2.1%	1.1%	1.2%	2.9%	1.1%	0.4%	2.7%	1.9%	2.0%	2.3%	0.7%	0.2%	3.6%	1.8%	1.5%	0.9%
	2 to 5 years ago	1.7%	2.0%	1.5%	1.8%	1.4%	1.1%	1.2%	2.2%	1.5%	1.8%	1.5%	1.7%	2.3%	3.3%	2.0%	2.2%	0.6%
	5 or more years ago	1.8%	2.5%	1.2%	2.1%	0.9%	3.9%	0.8%	2.8%	1.9%	1.8%	2.4%	1.7%	0.9%	4.5%	2.1%	1.4%	1.2%
	Don't know	0.5%	0.7%	0.4%	0.6%	0.5%	0.0%	0.3%	0.7%	0.7%	0.4%	0.5%	0.6%	0.7%	1.1%	0.9%	0.6%	0.1%
	Refused	0.1%	0.0%	0.1%	0.0%	0.0%	0.9%	0.0%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.2%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Question	Response	Planning Districts																
		Joelton	Belshire / Union Hill	Bordeaux/Whites Creek	Madison/Goodlettsville	East Nashville/Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/ West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage	
1998 - Adults age 18 to 64																		
Do you have any kind of health coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?		N*=154	N*=179	N*=167	N*=169	N*=171	N*=176	N*=161	N*=159	N*=146	N*=165	N*=162	N*=154	N*=184	N*=195	N*=207	N*=204	
	Yes	90.4%	86.9%	88.5%	85.6%	91.2%	94.2%	92.6%	88.2%	83.0%	84.5%	94.2%	91.7%	92.7%	92.4%	92.9%	90.8%	
	No	9.6%	13.1%	11.5%	14.4%	8.9%	5.8%	7.4%	11.8%	16.0%	15.5%	5.8%	7.8%	7.3%	7.6%	7.2%	9.3%	
	Don't know	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
About how long has it been since you had health care coverage?		N*=154	N*=179	N*=167	N*=169	N*=171	N*=176	N*=161	N*=159	N*=146	N*=165	N*=162	N*=154	N*=184	N*=195	N*=207	N*=204	
	Skipped	90.4%	86.9%	88.5%	85.6%	91.2%	94.2%	92.6%	88.2%	84.0%	84.5%	94.2%	92.2%	92.7%	92.4%	92.9%	90.8%	
	1 to 6 months ago	1.8%	4.0%	3.8%	3.6%	3.4%	1.8%	3.1%	3.5%	3.3%	2.2%	3.1%	1.2%	2.6%	1.8%	1.4%	3.6%	
	6 to 12 months ago	2.7%	0.7%	2.6%	2.7%	1.4%	0.0%	0.4%	0.8%	2.3%	2.8%	0.5%	1.5%	2.2%	0.7%	0.9%	0.0%	
	1 to 2 years ago	1.1%	3.9%	3.0%	1.7%	0.6%	1.3%	0.0%	0.6%	4.6%	4.3%	0.3%	0.6%	1.0%	0.7%	1.4%	0.7%	
	2 to 5 years ago	0.9%	2.1%	1.5%	3.3%	2.7%	1.3%	1.3%	2.3%	2.7%	0.8%	0.0%	1.2%	1.4%	1.8%	2.5%	1.3%	
	5 or more years ago	3.1%	1.7%	0.6%	1.5%	0.8%	0.5%	1.4%	3.8%	2.2%	4.7%	0.8%	2.7%	0.0%	1.8%	0.6%	3.7%	
	Don't know	0.0%	0.7%	0.0%	1.6%	0.0%	0.8%	1.3%	0.9%	0.9%	0.3%	0.6%	0.6%	0.0%	0.8%	0.4%	0.0%	
	Refused	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1998.

Data Table 21. Population Density, Nashville, Tennessee, and the United States, 2000

	Nashville	Tennessee	U.S.
Persons/square mile	1,135.20	138.00	79.60
Land area square miles	502.00	41,217.00	3,537,441.00

Source: U.S. Census Bureau

Data Table 22. Population Density by Gender, Race, Ethnicity, and Public Health Planning District, Nashville, TN, 2000

Area	Population										Area	Population Density, Person Per Square Mile								Area
Name	HPD	Total	Male	Female	Black	White	Other	Hispanic	Asian	Sq. Miles	Total	Male	Female	Black	White	Other	Hispanic	Asian	Name	
1. Joelton	1	5,026	2,523	2,503	169	4,779	78	38	13	39.55	127.1	63.80	63.28	4.27	120.83	1.98	0.95	0.34	1. Joelton	
2. Bellshire/Union Hill	2	17,820	8,417	9,403	8,306	9,051	463	228	100	41.97	424.6	200.56	224.05	197.91	215.66	11.04	5.42	2.38	2. Bellshire/Union Hill	
3. Bordeaux/Whites Creek	3	25,229	11,395	13,833	18,282	6,344	603	225	94	71.44	353.2	159.51	193.64	255.91	88.80	8.44	3.16	1.31	3. Bordeaux/Whites Creek	
4. Madison/Goodlettsville	4	41,229	19,476	21,753	7,304	31,277	2,648	2,139	446	26.67	1,545.7	730.16	815.52	273.83	1,172.58	99.27	80.19	16.72	4. Madison/Goodlettsville	
5. East Nashville/Inglewood	5	64,840	30,978	33,862	28,961	32,366	3,513	2,088	627	20.64	3,141.1	1,500.71	1,640.43	1,403.01	1,567.96	170.17	101.15	30.38	5. East Nashville/Inglewood	
6. Bellevue	6	34,006	15,982	18,024	1,735	30,204	2,067	649	1,240	70.38	483.2	227.08	256.10	24.66	429.15	29.37	9.22	17.62	6. Bellevue	
7a. The Nations/Sylvan Park	7a	12,791	7,658	5,134	2,862	8,995	934	844	192	9.07	1,410.9	844.63	566.24	315.69	992.18	103.00	93.12	21.15	7a. The Nations/Sylvan Park	
7b. Belle Meade/West Meade	7b	26,991	13,067	13,924	1,881	23,190	1,920	611	1,102	16.29	1,656.6	802.01	854.58	115.45	1,423.31	117.84	37.51	67.66	7b. Belle Meade/West Meade	
8. North Nashville	8	22,584	9,805	12,779	20,928	1,121	536	192	84	7.49	3,014.9	1,308.97	1,705.92	2,793.73	149.62	71.54	25.66	11.24	8. North Nashville	
9. Downtown	9	3,401	2,607	794	1,429	1,803	169	142	64	2.77	1,227.3	940.82	286.45	515.60	650.68	60.99	51.33	22.99	9. Downtown	
10a. West End/Vanderbilt	10a	32,286	15,503	16,782	10,641	19,134	2,511	738	1,623	6.45	5,008.9	2,405.25	2,603.67	1,650.82	2,968.52	389.59	114.44	251.85	10a. West End/Vanderbilt	
10b. Forest Hills/Oak Hill	10b	42,182	19,258	22,924	895	40,030	1,257	460	690	32.63	1,292.9	590.25	702.60	27.43	1,226.89	38.53	14.11	21.14	10b. Forest Hills/Oak Hill	
11. Berry Hill/Woodbine	11	33,775	16,997	16,778	8,651	20,077	5,047	4,284	1,197	15.44	2,187.7	1,100.96	1,086.76	560.33	1,300.47	326.91	277.48	77.56	11. Berry Hill/Woodbine	
12. Tusculum/Crieve Hall	12	77,441	37,869	39,573	13,477	55,149	8,816	6,221	2,715	42.70	1,813.5	886.79	926.69	315.59	1,291.45	206.44	145.67	63.58	12. Tusculum/Crieve Hall	
13. Priest Lake/Antioch	13	57,579	29,086	28,493	15,036	36,844	5,699	4,019	2,074	59.45	968.6	489.29	479.31	252.93	619.80	95.87	67.61	34.90	13. Priest Lake/Antioch	
14. Donelson/Hermitage	14	72,711	35,243	37,468	7,141	61,419	4,151	3,213	1,013	62.46	1,164.1	564.25	599.87	114.32	983.34	66.46	51.44	16.22	14. Donelson/Hermitage	
		569,891	275,865	294,026	147,696	381,783	40,412	26,091	13,275	525.40	1,084.7	525.06	559.63	281.11	726.66	76.92	49.66	25.27		

Data Source: 2000 Census Data

Data Table 23. Population Density by Gender, Race, Ethnicity, and Council District (1991-2002), Nashville, TN, 2000
Data Table 23-1

Council District	Population								Sq. Miles	Population Density, Persons Per Square Mile								Council District
	Total	Male	Female	Black	White	Other	Hispanic	Asian		Total	Male	Female	Black	White	Other	Hispanic	Asian	
1	15,114	7,066	8,048	5,804	8,949	361	113	58	98.3	153.8	71.9	81.9	39.1	91.1	3.7	1.1	0.6	1
2	15,098	6,891	8,207	12,277	2,307	514	378	87	9.6	1,580.4	721.3	859.1	1,285.1	241.5	53.8	39.6	7.0	2
3	15,410	7,178	8,232	4,272	10,404	734	500	189	14.5	1,065.3	496.2	569.1	295.3	719.2	50.7	34.6	13.1	3
4	16,790	7,854	8,936	10,453	5,635	702	418	174	8.0	2,099.5	982.1	1,117.4	1,307.1	704.6	87.8	52.3	21.8	4
5	13,839	6,431	7,408	10,077	3,014	748	534	53	3.4	4,036.9	1,875.9	2,160.9	2,939.5	879.2	218.2	155.8	15.5	5
6	14,182	6,781	7,401	5,748	7,512	922	373	167	3.6	3,953.2	1,890.2	2,063.0	1,602.2	2,094.0	257.0	104.0	46.6	6
7	14,911	7,194	7,717	6,718	7,578	615	365	135	5.3	2,824.9	1,362.9	1,462.0	1,272.7	1,435.7	116.5	69.1	25.6	7
8	15,537	7,358	8,179	2,596	11,994	947	546	165	5.1	3,034.6	1,437.1	1,597.5	507.0	2,342.6	185.0	106.6	32.2	8
9	17,376	8,474	8,902	3,142	12,966	1,268	1,257	122	11.1	1,568.0	764.7	803.3	283.5	1,170.1	114.4	113.4	11.0	9
10	16,013	7,651	8,362	2,013	13,500	500	238	150	42.1	380.5	181.8	198.7	47.8	320.8	11.9	5.7	3.6	10
11	16,963	8,104	8,859	1,163	15,217	583	381	162	16.0	1,058.6	505.8	552.9	72.6	949.7	36.4	23.8	10.1	11
12	21,240	10,155	11,085	2,604	17,459	1,177	808	332	35.9	591.3	282.7	308.6	72.5	486.0	32.8	22.5	9.2	12
13	17,264	8,224	8,040	2,764	11,238	3,262	3,105	542	14.5	1,194.5	638.2	556.3	191.2	777.6	225.7	214.8	37.5	13
14	14,373	7,013	7,360	1,590	12,186	597	431	176	9.0	1,600.2	780.8	819.4	177.0	1,358.7	66.5	48.0	19.6	14
15	15,302	7,634	7,669	1,096	12,765	1,532	1,490	187	16.7	914.8	456.4	458.5	60.1	783.1	91.6	89.1	11.2	15
16	14,439	7,353	7,086	1,656	10,368	2,415	1,954	650	5.6	2,588.1	1,318.0	1,270.1	296.8	1,858.4	432.9	350.2	116.5	16
17	12,541	5,780	6,761	7,212	4,820	509	209	214	3.8	3,326.3	1,533.0	1,793.2	1,912.8	1,278.4	135.0	55.4	56.8	17
18	14,646	7,051	7,595	851	12,220	1,575	391	1,162	2.0	7,284.3	3,506.9	3,777.4	423.3	6,077.7	783.3	194.5	577.9	18
19	13,650	6,669	6,981	8,881	4,040	729	450	264	4.9	2,805.5	1,370.7	1,434.8	1,825.3	830.4	149.8	92.5	54.3	19
20	13,666	6,549	7,117	11,952	1,373	341	175	42	5.5	2,484.3	1,190.5	1,293.8	2,172.7	249.6	62.0	31.8	7.6	20
21	15,122	7,192	7,930	9,892	4,261	969	743	276	4.3	3,489.0	1,659.4	1,829.7	2,282.3	983.1	223.6	171.4	63.7	21
22	14,822	8,511	6,311	2,564	10,834	1,424	431	804	10.1	1,461.3	839.1	622.2	752.8	1,068.2	140.4	42.5	79.3	22
23	17,716	8,582	9,134	952	15,644	1,120	359	607	43.9	403.2	195.3	207.9	21.7	356.0	25.5	8.2	13.8	23
24	15,059	7,190	7,869	1,555	12,652	852	341	391	6.6	2,272.2	1,084.9	1,187.3	234.6	1,909.0	128.6	51.5	59.0	24
25	15,892	7,154	8,538	396	14,760	336	179	309	4.6	3,388.6	1,544.9	1,843.7	85.5	3,187.3	115.7	38.7	66.7	25
26	16,617	8,261	8,356	3,528	10,153	2,936	2,293	554	4.4	3,760.2	1,869.4	1,890.9	798.3	2,297.5	664.4	518.9	125.4	26
27	17,073	9,021	8,052	4,777	10,486	1,870	1,107	765	9.1	1,885.1	906.0	889.1	527.4	1,511.2	206.5	122.2	84.5	27
28	21,137	10,358	10,779	5,519	13,206	2,412	1,612	1,068	8.7	2,425.9	1,188.8	1,237.1	633.4	1,515.7	276.8	185.0	122.6	28
29	21,186	10,306	10,880	5,650	14,200	1,336	683	577	17.7	1,196.2	581.9	614.3	319.0	801.8	75.4	38.6	32.6	29
30	14,830	7,469	7,461	3,240	9,627	2,063	1,770	490	3.5	4,317.3	2,159.8	2,157.5	936.9	2,783.8	596.6	511.8	141.7	30
31	21,136	10,266	10,870	4,342	15,036	1,758	1,029	757	25.5	829.6	403.0	426.7	170.4	590.2	69.0	40.4	29.7	31
32	19,312	9,192	10,120	1,288	16,739	1,285	769	571	7.4	2,615.1	1,244.7	1,370.4	174.4	2,266.7	174.0	104.1	77.3	32
33	15,177	7,203	7,974	174	14,637	366	130	216	20.6	736.1	349.4	386.8	8.4	710.0	17.8	6.3	10.5	33
34	15,202	6,894	8,308	146	14,719	337	156	163	14.4	1,056.5	479.1	577.4	10.1	1,023.0	23.4	10.8	11.3	34
35	21,355	9,856	11,499	19,344	1,117	373	716	30.0	712.7	328.9	383.8	29.8	645.6	37.3	12.4	23.9	35	35
Sum	569,891	275,865	294,026	147,696	381,783	40,412	26,091	13,275	525.6	1,084.3	524.9	559.4	281.0	726.4	76.9	49.6	25.3	Sum

Data Source: Metropolitan Planning Commission, 2000 Census Data with Council District (1991-2002)

Data Table 23. Population Density by Gender, Race, Ethnicity, and Council District (2003 forward), Nashville, TN, 2000
Data Table 23-2

Council District	Population								Sq. Miles	Population Density, Persons Per Square Mile								Council District
	Total	Male	Female	Black	White	Other	Hispanic	Asian		Total	Male	Female	Black	White	Other	Hispanic	Asian	
1	16,409	7,604	8,805	8,511	7,442	356	119	65	81.0	202.5	93.8	108.7	106.3	91.8	4.4	1.5	0.8	1
2	15,516	6,991	8,525	12,510	2,402	604	321	118	10.7	1,446.1	651.6	794.5	1,165.9	223.9	56.3	29.9	11.0	2
3	15,512	7,186	8,326	8,650	6,588	274	76	55	47.1	329.2	152.5	176.7	183.6	139.8	5.8	1.6	1.2	3
4	15,523	7,255	8,268	3,231	11,224	1,068	730	212	8.3	1,874.0	875.9	998.1	390.1	1,355.0	128.9	88.1	25.6	4
5	15,607	7,538	8,069	9,601	5,050	956	856	79	4.0	3,945.0	1,905.4	2,039.6	2,426.8	1,276.5	241.6	216.4	20.0	5
6	16,974	8,631	8,343	7,442	8,437	1,095	509	189	4.5	3,797.0	1,930.7	1,866.3	1,664.7	1,887.3	244.9	113.9	42.3	6
7	15,501	7,309	8,192	6,383	8,501	617	295	142	6.0	2,597.4	1,224.7	1,372.7	1,069.6	1,424.5	103.4	49.4	23.8	7
8	15,685	7,505	8,180	4,672	10,372	641	320	158	6.4	2,461.1	1,177.6	1,283.5	733.1	1,627.4	100.6	50.2	24.8	8
9	15,497	7,469	8,028	2,916	11,520	1,061	1,032	112	10.7	1,446.0	696.9	749.1	272.1	1,074.9	99.0	96.3	10.5	9
10	16,217	7,761	8,456	2,081	13,366	770	545	175	25.1	645.0	308.7	336.3	82.8	531.6	30.6	21.7	7.0	10
11	16,247	7,568	8,679	1,026	14,704	517	337	149	15.7	1,032.8	481.1	551.7	65.2	934.7	32.9	21.4	9.5	11
12	17,063	8,315	8,748	2,322	13,807	934	533	289	11.0	1,550.5	755.6	794.9	211.0	1,254.6	84.9	48.4	26.3	12
13	17,077	8,847	8,230	2,898	11,487	2,692	2,533	505	22.8	749.7	388.4	361.3	127.2	504.3	118.2	111.2	22.2	13
14	17,064	8,397	8,667	1,432	14,811	821	714	203	11.9	1,430.3	703.9	726.5	120.0	1,241.5	68.8	59.8	17.0	14
15	16,741	8,548	8,193	1,334	13,253	2,154	2,104	244	16.1	1,041.4	531.7	509.7	83.0	824.4	134.0	130.9	15.2	15
16	17,082	8,544	8,538	2,180	12,205	2,697	2,027	803	7.9	2,170.2	1,085.5	1,084.7	277.0	1,550.6	342.6	257.5	102.0	16
17	16,563	7,696	8,867	10,313	5,483	767	502	227	6.4	2,604.4	1,210.1	1,394.3	1,621.7	862.2	120.6	78.9	35.7	17
18	16,434	7,894	8,540	1,452	13,443	1,539	407	1,089	2.4	6,773.0	3,253.4	3,519.6	598.4	5,540.3	634.3	167.7	448.8	18
19	15,510	7,503	8,007	11,178	3,480	852	346	377	5.1	3,015.7	1,458.8	1,556.8	2,173.4	676.6	165.7	67.3	73.3	19
20	16,673	9,594	7,079	2,992	11,791	1,890	1,033	842	10.0	1,675.0	963.8	711.2	300.6	1,184.5	189.9	103.8	84.6	20
21	15,508	7,038	8,470	12,494	2,531	483	139	213	4.3	3,575.9	1,622.9	1,953.1	2,880.9	583.6	111.4	32.1	49.1	21
22	15,675	7,063	8,612	747	13,862	1,066	357	589	9.7	1,614.1	727.3	886.8	76.9	1,427.4	109.8	36.8	60.7	22
23	16,400	7,882	8,518	639	15,143	618	207	358	13.5	1,216.7	584.7	631.9	47.4	1,123.4	45.8	15.4	26.6	23
24	16,962	7,930	9,032	1,590	14,455	917	376	416	5.7	2,977.6	1,392.1	1,585.5	279.1	2,537.5	161.0	66.0	73.0	24
25	17,044	7,531	9,513	483	16,010	551	180	325	5.5	3,104.3	1,371.6	1,732.6	98.0	2,915.9	100.4	32.8	61.0	25
26	17,094	8,447	8,647	2,854	2,049	2,192	1,532	698	6.3	2,712.5	1,340.3	1,372.0	452.7	1,911.8	347.8	243.1	110.8	26
27	16,483	7,648	8,515	7,024	12,181	1,908	1,194	683	3.6	4,487.5	2,124.2	2,364.1	575.8	3,261.9	529.7	331.5	136.9	27
28	8,396	4,717	3,679	1,339	6,473	1,412	689	78	7.8	1,089.1	1,067.9	1,021.9	565.2	1,854.3	274.5	185.4	87.8	28
29	16,025	7,886	8,139	4,051	10,733	1,241	713	501	7.5	2,142.9	1,054.1	1,068.9	541.5	1,434.7	165.9	95.3	67.0	29
30	16,660	8,483	8,177	3,847	10,239	2,574	2,345	513	4.0	2,212.0	2,146.2	2,087.5	973.3	2,250.4	651.2	993.3	129.8	30
31	16,953	8,093	8,860	2,331	13,468	1,154	495	623	19.5	867.9	414.3	453.6	119.3	689.5	59.1	25.3	31.9	31
32	15,505	7,658	7,847	3,612	10,542	1,351	833	552	19.3	804.8	397.5	407.3	187.5	547.2	70.1	43.2	28.7	32
33	16,473	7,866	8,607	4,666	10,630	1,177	540	584	22.0	749.9	358.1	391.8	212.4	483.9	53.6	24.6	26.6	33
34	17,078	8,126	8,952	167	16,521	390	144	203	26.8	637.5	303.3	334.2	6.2	616.7	14.6	5.4	7.6	34
35	15,979	7,753	8,226	546	14,694	739	255	484	57.6	277.2	134.5	142.7	9.5	254.9	12.8	4.4	8.4	35
Sum	569,891	275,865	294,026	147,696	381,783	40,412	26,091	13,275	526.1	1,083.3	524.4	558.9	280.7	725.7	76.8	49.6	25.2	Sum

Data Table 24. Language Spoken at Home, Age 5 and Over, Nashville, TN, 1990 and 2000

2000	Persons	Percentage
English only	480,014	90.2
Language other than English	52,297	9.8
Spanish	26,174	4.9
Other	26,123	4.9
Population 5 years and over	532,311	
1990		
English	454,653	95.7
Language other than English	20,523	4.3
Spanish	6,401	1.3
Other	14,122	3.0
Population 5 years and over	475,176	

Data Table 25. Responses to BRFSS Questions about Physical Activity, Nashville, TN, 1996

			Gender			Race			Marital Status		Age Group						Highest Level of Education			
Question	Response	Total	Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree	
1996																				
During the past month, did you participate in any physical activities...?		N=2802	N*=1293	N*=1509	N*=2133	N*=617	N*=52	N*=1296	N*=1505	N*=388	N*=642	N*=614	N*=447	N*=295	N*=416	N*=394	N*=875	N*=697	N*=836	
	Yes	74.8%	79.3%	71.0%	76.7%	69.2%	64.9%	76.8%	73.1%	80.3%	81.2%	76.6%	74.9%	68.6%	61.5%	56.0%	68.5%	79.0%	86.8%	
How many times...did you take part in this activity...?	No	25.2%	20.7%	29.0%	23.3%	30.8%	35.2%	23.2%	26.9%	19.8%	18.8%	23.4%	25.1%	31.4%	38.5%	44.0%	31.5%	21.0%	13.2%	
		N=2084	N*=1018	N*=1066	N*=1624	N*=426	N*=34	N*=988	N*=1095	N*=311	N*=517	N*=469	N*=334	N*=198	N*=255	N*=218	N*=595	N*=551	N*=720	
	less than 1 time/week	4.3%	5.6%	3.1%	4.4%	4.0%	3.7%	4.8%	3.8%	4.1%	5.0%	5.6%	3.8%	2.9%	2.3%	7.4%	4.1%	3.9%	3.7%	
	1 time/week	10.3%	12.3%	8.4%	10.6%	9.5%	7.8%	11.5%	9.2%	9.2%	11.3%	10.9%	12.1%	8.5%	7.4%	8.9%	9.7%	9.3%	11.9%	
	2 times/week	18.8%	20.4%	17.4%	19.1%	17.6%	19.9%	19.3%	18.5%	22.4%	21.0%	18.9%	18.9%	16.0%	12.0%	14.5%	18.6%	23.9%	16.5%	
	3 times/week	26.4%	23.4%	29.2%	25.6%	30.0%	17.4%	26.5%	26.2%	26.5%	26.9%	26.6%	27.9%	24.2%	24.4%	18.3%	27.8%	27.9%	26.5%	
	4 times/week	11.2%	10.6%	11.9%	11.8%	8.2%	21.3%	11.5%	11.0%	9.4%	12.6%	11.9%	10.3%	11.9%	10.1%	8.4%	8.6%	11.1%	14.4%	
	5 times/week	12.4%	11.6%	13.1%	12.5%	12.0%	9.0%	13.0%	11.9%	10.6%	11.4%	12.2%	12.9%	15.8%	13.4%	13.4%	11.4%	12.5%	12.8%	
	6 times/week	2.9%	2.9%	2.9%	2.8%	3.1%	7.0%	3.0%	2.8%	3.5%	3.5%	2.1%	3.3%	0.8%	3.4%	2.7%	2.9%	1.4%	4.1%	
	7 times/week	11.9%	11.7%	12.1%	11.4%	13.9%	10.8%	9.1%	14.4%	13.1%	6.9%	10.7%	8.8%	18.0%	22.0%	22.2%	13.9%	8.9%	9.4%	
	unknown	1.8%	1.6%	2.0%	1.8%	1.8%	3.3%	1.4%	2.2%	1.1%	1.3%	1.1%	2.0%	1.8%	5.0%	4.2%	2.9%	1.2%	0.7%	
When you took part in this activity, for how many minutes or hours did you usually keep it up?		N=2077	N*=1013	n*=1064	N*=1619	N*=424	N*=34	N*=983	N*=1093	N*=311	N*=514	N*=468	N*=334	N*=197	N*=253	N*=217	N*=593	N*=548	N*=719	
	less than 30 minutes	6.0%	5.7%	6.3%	6.3%	5.2%	2.8%	6.2%	5.8%	5.8%	4.0%	7.0%	6.2%	5.6%	8.3%	6.6%	5.5%	7.4%	5.2%	
	30-60 minutes	58.5%	48.2%	68.3%	59.0%	56.0%	64.0%	59.8%	57.3%	52.2%	56.2%	60.2%	61.7%	65.1%	58.1%	51.8%	56.8%	55.6%	64.0%	
	1-2 hours	18.0%	22.4%	13.9%	16.9%	22.2%	20.8%	16.8%	19.1%	24.5%	23.3%	15.9%	17.4%	9.9%	10.6%	19.0%	19.1%	17.9%	16.9%	
	more than 2 hours	11.6%	18.1%	5.3%	12.0%	10.0%	10.0%	12.0%	11.2%	12.9%	11.5%	11.6%	10.3%	10.1%	12.7%	13.1%	10.3%	12.3%	11.6%	
	unknown	6.0%	5.7%	6.3%	5.9%	6.7%	2.5%	5.2%	6.7%	4.6%	5.1%	5.2%	4.5%	9.3%	10.4%	9.6%	8.3%	6.8%	2.4%	

*Numbers have been adjusted to match the gender-race age distribution of Nashville, TN for 1996.

Table 25 continued. Responses to BRFSS Questions about Physical Activity, Nashville, TN, 1996

Question	Response	Planning Districts													
		Joelton	Belshire/ Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts- ville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1996															
During the past month, did you participate in any physical activities...?		N*=176	N*=200	N*=189	N*=215	N*=190	N*=208	N*=218	N*=174	N*=179	N*=199	N*=206	N*=213	N*=218	N*=216
	Yes	72.4%	73.5%	70.6%	75.2%	73.4%	78.4%	78.1%	65.4%	67.0%	76.6%	77.6%	76.9%	79.0%	79.5%
How many times...did you take part in this activity...?	No	27.6%	26.5%	29.4%	24.8%	26.7%	21.6%	21.9%	34.6%	33.0%	23.4%	22.5%	23.1%	21.0%	20.6%
		N*=126	N*=145	N*=131	N*=162	N*=139	N*=163	N*=170	N*=114	N*=120	N*=151	N*=159	N*=164	N*=172	N*=168
	less than 1 time/week	5.1%	3.8%	6.0%	3.7%	2.6%	4.0%	7.1%	2.5%	5.8%	0.7%	3.8%	6.9%	4.3%	3.2%
	1 time/week	7.2%	10.4%	12.6%	9.1%	10.7%	12.5%	10.2%	9.3%	5.7%	12.6%	10.7%	9.6%	11.0%	10.7%
	2 times/week	18.2%	19.6%	17.1%	25.1%	20.7%	13.8%	16.1%	17.0%	19.1%	14.4%	20.4%	20.6%	20.0%	20.8%
	3 times/week	32.4%	26.9%	27.4%	18.7%	22.4%	25.6%	27.5%	25.3%	26.3%	30.0%	27.2%	28.4%	24.2%	27.9%
	4 times/week	9.1%	14.9%	2.4%	16.2%	10.1%	12.9%	15.2%	9.8%	5.6%	15.9%	10.2%	9.3%	13.8%	8.1%
	5 times/week	11.2%	13.0%	10.3%	10.3%	15.0%	15.1%	10.7%	9.7%	14.3%	15.8%	6.8%	10.3%	9.2%	21.1%
	6 times/week	1.1%	0.6%	4.9%	1.9%	2.2%	5.3%	3.0%	6.0%	3.6%	3.2%	2.7%	2.8%	3.1%	1.1%
	7 times/week	13.0%	7.7%	14.8%	12.4%	13.3%	10.5%	10.2%	18.0%	18.2%	7.1%	16.6%	10.7%	11.3%	6.8%
	unknown	2.6%	3.0%	4.5%	2.7%	3.1%	0.4%	0.0%	2.4%	1.4%	0.3%	1.6%	1.4%	3.0%	0.4%
When you took part in this activity, for how many minutes or hours did you usually keep it up?		N*=124	N*=145	N*=131	N*=161	N*=138	N*=163	N*=169	N*=114	N*=119	N*=150	N*=160	N*=162	N*=172	N*=168
	less than 30 minutes	9.0%	1.6%	8.1%	5.5%	8.9%	11.3%	7.7%	5.4%	9.8%	6.7%	2.2%	1.2%	2.4%	5.9%
	30-60 minutes	54.3%	49.6%	53.6%	59.9%	55.5%	54.5%	66.4%	53.7%	52.2%	56.5%	66.1%	65.4%	60.3%	63.3%
	1-2 hours	20.4%	28.7%	12.3%	19.6%	17.6%	16.9%	12.0%	20.6%	22.1%	25.0%	11.3%	15.9%	16.3%	16.8%
	more than 2 hours	10.8%	11.9%	12.3%	13.0%	11.0%	12.1%	11.3%	10.1%	10.7%	9.7%	11.4%	11.8%	15.5%	9.4%
	unknown	5.5%	8.1%	13.7%	2.1%	7.0%	5.3%	2.6%	10.2%	5.3%	2.1%	9.0%	5.7%	5.5%	4.6%

*Numbers have been adjusted to match the gender-race age distribution of Nashville, TN for 1996.

Data Table 26. Responses to BRFSS Questions about Physical Activity, Nashville, TN, 1998

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998		N*=3230	N*=1488	N*=1742	N*=2447	N*=722	N*=61	N*=1499	N*=1724	N*=438	N*=702	N*=726	N*=549	N*=337	N*=478	N*=369	N*=983	N*=843	N*=1035
During the past month, did you participate in any physical activities...?	Yes	80.2%	82.5%	78.2%	82.0%	74.5%	75.9%	83.4%	77.5%	86.9%	85.3%	83.1%	77.9%	74.8%	68.5%	64.8%	77.4%	81.8%	87.0%
	No	18.8%	16.3%	21.0%	17.2%	24.1%	21.0%	15.7%	21.5%	11.2%	14.4%	16.1%	20.9%	24.4%	30.1%	31.9%	21.8%	17.7%	12.3%
	Refused	1.0%	1.2%	0.8%	0.9%	1.3%	3.1%	0.9%	1.0%	1.9%	0.3%	0.8%	1.2%	0.8%	1.4%	3.3%	0.9%	0.5%	0.7%
How many times...did you take part in this activity...?		N*=2590	N*=1228	N*=1362	N*=2005	N*=538	N*=46	N*=1250	N*=1336	N*=381	N*=599	N*=603	N*=428	N*=252	N*=327	N*=239	N*=761	N*=690	N*=900
	less than 1 time/week	24.7%	24.8%	24.6%	24.8%	25.0%	15.1%	24.3%	25.0%	20.1%	29.8%	22.8%	28.5%	21.5%	21.5%	18.8%	27.3%	22.0%	26.0%
	1 time/week	24.7%	25.6%	24.0%	25.1%	23.8%	23.0%	23.6%	25.8%	26.3%	22.6%	24.6%	24.9%	20.9%	30.0%	30.4%	24.3%	26.7%	22.2%
	2 times/week	9.2%	8.8%	9.5%	9.1%	9.6%	5.0%	9.7%	8.7%	7.4%	12.7%	9.6%	7.0%	10.2%	5.9%	11.2%	7.7%	9.1%	9.9%
	3 times/week	15.9%	14.2%	17.5%	16.4%	14.2%	17.9%	17.5%	14.5%	17.0%	14.5%	16.9%	16.4%	18.1%	13.4%	11.5%	14.4%	16.3%	18.1%
	4 times/week	3.5%	3.3%	3.8%	3.3%	3.6%	12.2%	3.0%	4.0%	4.3%	3.1%	3.9%	2.9%	2.8%	4.1%	3.4%	3.6%	3.4%	3.6%
	5 times/week	9.3%	10.1%	8.5%	9.2%	9.5%	9.9%	8.8%	9.7%	12.9%	7.3%	9.8%	6.3%	12.7%	8.7%	8.4%	9.7%	9.4%	9.0%
	6 times/week	3.2%	3.3%	3.2%	3.1%	3.6%	4.3%	3.3%	3.2%	3.6%	2.9%	2.8%	4.5%	2.0%	3.5%	3.0%	3.1%	3.1%	3.6%
	7 times/week	8.3%	9.2%	7.5%	7.9%	9.6%	8.9%	8.5%	8.1%	8.1%	5.7%	8.7%	8.4%	10.6%	10.7%	10.9%	8.9%	9.1%	6.5%
	unknown	1.2%	0.8%	1.5%	1.1%	1.2%	3.8%	1.3%	1.1%	0.3%	1.5%	0.9%	1.1%	1.0%	2.2%	2.4%	1.0%	0.9%	1.1%
When you took part in this activity, for how many minutes or hours did you usually keep it up?		N*=2590	N*=1228	N*=1362	N*=2005	N*=538	N*=46	N*=1250	N*=1336	N*=381	N*=599	N*=603	N*=428	N*=252	N*=327	N*=239	N*=761	N*=690	N*=900
	less than 30 minutes	40.6%	31.5%	48.8%	41.5%	37.0%	44.0%	42.0%	39.3%	31.8%	39.3%	39.5%	39.6%	51.0%	48.8%	50.4%	42.4%	39.1%	37.8%
	30-60 minutes	38.5%	39.2%	38.8%	38.6%	34.7%	33.1%	38.0%	39.0%	40.1%	41.3%	40.0%	33.0%	30.6%	26.8%	35.9%	40.0%	42.5%	
	1-2 hours	12.8%	17.8%	8.3%	11.6%	17.3%	13.8%	11.5%	14.1%	20.9%	12.6%	13.5%	10.9%	6.8%	9.4%	12.4%	13.3%	12.3%	12.8%
	more than 2 hours	5.0%	7.9%	2.5%	4.6%	6.7%	1.3%	5.3%	4.7%	5.3%	5.4%	3.4%	6.1%	6.2%	4.6%	4.8%	5.4%	5.5%	4.4%
	unknown	3.1%	3.7%	2.6%	2.7%	4.3%	7.8%	3.3%	3.0%	1.9%	2.6%	2.3%	3.5%	3.0%	6.7%	5.7%	3.0%	3.1%	2.5%

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1998.

Table 26 continued. Responses to BRFSS Questions about Physical Activity, Nashville, TN, 1998

Question	Response	Planning Districts															
		Joelton	Belshire/ Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/ West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1998		N*=182	N*=206	N*=199	N*=199	N*=193	N*=208	N*=202	N*=205	N*=179	N*=187	N*=206	N*=194	N*=206	N*=216	N*=222	N*=227
During the past month, did you participate in any physical activities...?	Yes	82.7%	78.9%	74.4%	83.9%	70.0%	82.8%	83.2%	87.1%	68.6%	76.0%	81.5%	80.2%	81.6%	80.6%	87.3%	81.0%
	No	17.3%	21.1%	24.4%	15.7%	28.5%	15.3%	16.0%	11.8%	28.9%	22.4%	17.8%	19.6%	16.4%	18.8%	11.8%	18.2%
	Refused	0.0%	0.0%	1.1%	0.4%	1.5%	2.0%	0.8%	1.1%	2.5%	1.6%	0.8%	0.3%	2.0%	0.6%	0.9%	0.7%
How many times...did you take part in this activity...?		N*=151	N*=163	N*=148	N*=167	N*=135	N*=172	N*=168	N*=179	N*=123	N*=142	N*=168	N*=155	N*=168	N*=174	N*=194	N*=184
	less than 1 time/week	23.4%	23.7%	27.3%	26.7%	26.8%	22.6%	23.8%	23.3%	20.6%	21.5%	23.6%	25.3%	30.9%	24.4%	26.0%	23.7%
	1 time/week	17.8%	30.1%	18.0%	24.9%	33.0%	26.0%	23.8%	29.7%	23.6%	25.4%	25.4%	35.4%	21.7%	26.6%	21.2%	15.3%
	2 times/week	13.0%	5.9%	10.9%	5.5%	7.0%	7.6%	9.4%	10.8%	9.5%	9.3%	10.3%	4.5%	9.0%	7.7%	10.6%	14.5%
	3 times/week	20.5%	14.9%	28.9%	14.1%	10.8%	21.0%	14.2%	10.4%	22.2%	10.1%	15.6%	11.1%	16.0%	14.7%	14.4%	17.9%
	4 times/week	5.0%	3.2%	2.1%	3.2%	5.5%	4.7%	4.5%	4.1%	3.5%	1.0%	2.4%	3.6%	1.6%	6.0%	4.1%	2.0%
	5 times/week	9.2%	10.6%	3.9%	10.2%	6.7%	6.3%	10.3%	10.2%	8.5%	16.6%	11.1%	9.4%	7.3%	9.5%	7.1%	11.2%
	6 times/week	1.8%	1.5%	0.9%	6.3%	2.2%	1.7%	4.1%	4.8%	3.7%	2.6%	4.5%	1.1%	3.2%	3.2%	5.3%	3.8%
	7 times/week	7.7%	8.8%	6.9%	8.0%	6.7%	9.6%	8.5%	4.8%	7.8%	11.9%	6.8%	7.7%	10.3%	6.9%	10.2%	10.0%
	unknown	1.6%	1.4%	1.2%	1.1%	1.4%	0.5%	1.4%	1.9%	0.6%	1.7%	0.6%	1.8%	0.0%	1.0%	1.1%	1.4%
When you took part in this activity, for how many minutes or hours did you usually keep it up?		N*=151	N*=163	N*=148	N*=167	N*=135	N*=172	N*=168	N*=179	N*=123	N*=142	N*=168	N*=155	N*=168	N*=174	N*=194	N*=184
	less than 30 minutes	44.5%	37.9%	40.5%	43.0%	46.5%	40.9%	37.4%	44.2%	45.0%	40.9%	40.2%	39.4%	44.3%	34.1%	34.4%	40.3%
	30-60 minutes	34.2%	36.0%	37.0%	38.8%	35.7%	37.3%	40.5%	41.3%	36.1%	39.1%	39.2%	38.7%	37.3%	39.3%	37.6%	45.0%
	1-2 hours	9.8%	18.8%	14.0%	12.6%	8.9%	9.6%	17.5%	7.4%	11.5%	11.4%	16.9%	15.1%	5.9%	16.5%	18.8%	8.6%
	more than 2 hours	6.8%	5.5%	4.0%	3.1%	5.4%	7.2%	2.8%	4.5%	4.3%	2.9%	2.4%	5.4%	9.6%	5.1%	6.6%	4.0%
	unknown	4.7%	1.8%	4.6%	2.5%	3.4%	5.0%	1.9%	2.7%	3.1%	5.7%	1.3%	1.3%	2.8%	5.0%	2.6%	2.0%

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1998.

Data Table 27. Calculated Body Mass Index from Height and Weight Responses to BRFSS, Nashville, TN.

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1996 Adults		N=2696	N*=1279	N*=1417	N*=2058	N*=587	N*=51	N*=1256	N*=1440	N*=374	N*=619	N*=591	N*=434	N*=285	N*=393	N*=368	N*=844	N*=679	N*=805
Body Mass Index calculated from self-reported height and weight.	Normal ¹	50.7%	43.1%	57.5%	53.7%	38.6%	68.3%	48.3%	52.8%	63.9%	57.5%	49.7%	39.1%	40.3%	49.1%	40.4%	47.8%	52.6%	56.8%
	Overweight ²	32.9%	39.9%	26.6%	31.9%	37.2%	24.1%	34.9%	31.2%	26.2%	29.4%	31.7%	37.8%	38.6%	37.2%	32.3%	35.2%	31.8%	31.8%
	Obese ³	16.4%	17.0%	15.9%	14.4%	24.2%	7.6%	16.8%	16.0%	9.8%	13.1%	18.6%	23.1%	21.1%	13.7%	27.3%	17.1%	15.6%	11.4%
	Planning Districts																		
	Response	Joelton	Belshire / Union Hill	Bordeaux / Whites Creek	Madison / Goodletts-ville	East Nashville / Inglewood	Bellevue	Belle Meade / West Meade	North Nashville	Downtown	Forest Hills / Oak Hill	Berry Hill / Woodbine	Tusculum / Crieve Hall	Priest Lake / Antioch	Donelson / Hermitage				
		N*=171	N*=189	N*=185	N*=207	N*=187	N*=198	N*=211	N*=162	N*=172	N*=196	N*=194	N*=205	N*=207	N*=212				
	Normal ¹	36.4%	44.0%	44.8%	56.4%	43.6%	59.5%	56.2%	46.4%	37.7%	63.2%	49.8%	54.3%	54.2%	56.4%				
	Overweight ²	44.6%	36.9%	35.1%	29.8%	33.1%	24.3%	33.6%	33.4%	35.1%	26.1%	36.0%	29.6%	34.4%	31.5%				
	Obese ³	19.0%	19.1%	20.1%	13.9%	23.3%	16.2%	10.2%	20.3%	27.2%	10.7%	14.2%	16.1%	11.3%	12.1%				
Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998 Adults		N=3094	N*=1464	N*=1630	N*=2344	N*=691	N*=59	N*=1430	N*=1659	N*=423	N*=689	N*=687	N*=529	N*=322	N*=444	N*=342	N*=942	N*=802	N*=1008
Body Mass Index calculated from self-reported height and weight.	Normal ¹	47.2%	40.2%	53.4%	51.0%	32.9%	62.1%	44.4%	49.5%	61.4%	51.7%	44.7%	38.8%	36.6%	48.1%	40.5%	45.2%	45.3%	52.8%
	Overweight ²	33.9%	42.0%	26.7%	32.5%	39.7%	24.0%	35.8%	32.4%	27.0%	30.9%	35.6%	37.6%	37.5%	35.6%	33.6%	33.7%	34.2%	34.0%
	Obese ³	18.9%	17.9%	19.9%	16.5%	27.4%	13.9%	19.7%	18.2%	11.6%	17.4%	19.7%	23.6%	26.0%	16.3%	25.8%	21.1%	20.6%	13.2%
	Planning Districts																		
	Response	Joelton	Belshire / Union Hill	Bordeaux / Whites Creek	Madison / Goodletts-ville	East Nashville / Inglewood	Bellevue	The Nations / Sylvan Park	Belle Meade / West Meade	North Nashville	Downtown	West End / Vanderbilt	Forest Hills / Oak Hill	Berry Hill / Woodbine	Tusculum / Crieve Hall	Priest Lake / Antioch	Donelson / Hermitage		
		N*=174	N*=200	N*=192	N*=189	N*=181	N*=196	N*=195	N*=198	N*=169	N*=177	N*=204	N*=185	N*=198	N*=205	N*=213	N*=218		
	Normal ¹	37.9%	45.3%	38.7%	43.7%	35.4%	56.7%	55.8%	50.7%	38.3%	42.7%	53.6%	49.6%	47.7%	53.1%	51.7%	49.1%		
	Overweight ²	43.1%	37.4%	37.1%	35.3%	39.2%	28.9%	30.9%	35.8%	32.3%	29.6%	32.2%	34.5%	36.3%	30.6%	34.0%	27.5%		
	Obese ³	19.0%	17.4%	24.3%	21.0%	25.4%	14.4%	13.4%	13.5%	29.5%	27.8%	14.2%	15.9%	16.1%	16.4%	14.2%	23.4%		

*Numbers have been adjusted to match the gender-race-age distribution of Davidson County, TN for 1996 and 1998.

¹ Normal Body Mass Index is defined as below 25.0 kg/m².

² Overweight Body Mass Index is defined as between 25.0 kg/m² and 29.9 kg/m².

³ Obese Body Mass Index is defined as 30.0 kg/m² or higher.

Data Table 28. Responses to BRFSS Questions about Smoking, Nashville, TN, 1996 and 1998

Data Table 20: Responses to 2015 Survey Questions about Smoking, Nashville, TN, 2006 and 2008																			
Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1996 Adults																			
Do you now smoke cigarettes everyday, some days, or not at all?		N=2802	N*=1293	N*=1509	N*=2133	N*=617	N*=52	N*=1296	N*=1505	N*=388	N*=642	N*=614	N*=448	N*=295	N*=416	N*=394	N*=875	N*=697	N*=836
	Everyday	23.1%	23.5%	22.8%	25.0%	16.6%	22.8%	21.8%	24.3%	18.9%	24.1%	29.9%	26.8%	25.4%	9.9%	33.5%	30.4%	22.3%	11.3%
	Some days	5.3%	6.1%	4.7%	4.9%	6.7%	8.3%	4.7%	5.9%	5.4%	5.9%	6.0%	5.1%	4.6%	4.2%	6.2%	4.8%	6.2%	4.8%
	Not at all	18.4%	21.6%	15.6%	20.2%	12.6%	11.2%	21.1%	16.0%	7.9%	12.0%	15.7%	24.1%	25.3%	30.8%	18.5%	16.6%	18.7%	19.9%
	Not asked /Refused	53.2%	49.0%	57.0%	49.9%	64.0%	57.8%	52.4%	53.9%	67.8%	58.0%	48.4%	44.0%	44.7%	55.1%	41.8%	48.2%	52.9%	64.1%
		Planning Districts																	
	Response	Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	Belle Meade/West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage				
		N*=176	N*=200	N*=189	N*=215	N*=190	N*=208	N*=219	N*=174	N*=179	N*=199	N*=206	N*=213	N*=218	N*=216				
	Everyday	15.7%	31.6%	23.6%	26.8%	21.6%	19.4%	16.4%	28.0%	25.1%	17.4%	26.8%	26.8%	27.1%	17.4%				
	Some days	7.0%	7.2%	4.0%	2.8%	6.8%	1.4%	6.2%	4.9%	7.2%	6.4%	6.0%	5.7%	4.8%	5.0%				
	Not at all	15.8%	16.0%	17.1%	20.7%	12.6%	19.9%	24.4%	15.0%	15.7%	24.0%	23.5%	12.2%	17.0%	21.1%				
Not asked /Refused	61.4%	45.2%	55.3%	49.7%	59.0%	59.2%	53.0%	52.2%	52.0%	52.3%	43.7%	55.3%	51.1%	56.5%					
Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998 Adults																			
Do you now smoke cigarettes everyday, some days, or not at all?		N=3230	N*=1488	N*=1742	N*=2447	N*=723	N*=61	N*=1499	N*=1724	N*=438	N*=702	N*=726	N*=549	N*=337	N*=477	N*=369	N*=983	N*=843	N*=1035
	Everyday	21.2%	22.8%	19.8%	22.6%	16.4%	22.0%	18.4%	23.6%	17.3%	21.2%	28.5%	24.1%	22.0%	9.5%	32.7%	27.2%	21.3%	11.2%
	Some days	5.9%	6.2%	5.6%	5.5%	6.9%	7.9%	3.9%	7.5%	7.1%	6.4%	6.8%	5.2%	6.5%	3.0%	7.6%	5.8%	5.4%	5.8%
	Not at all	72.7%	70.6%	74.5%	71.6%	76.7%	69.3%	77.4%	68.7%	75.6%	72.0%	64.4%	70.7%	71.1%	87.1%	59.0%	66.9%	73.1%	82.8%
	Not asked /Refused	0.2%	0.4%	0.1%	0.3%	0.1%	0.7%	0.4%	0.1%	0.0%	0.4%	0.3%	0.0%	0.4%	0.3%	0.6%	0.1%	0.2%	0.2%
		Planning Districts																	
	Response	Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade /West Meade	North Nashville	Down-town	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Wood-bine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson /Hermitage		
		N*=182	N*=206	N*=199	N*=199	N*=193	N*=208	N*=202	N*=205	N*=179	N*=187	N*=206	N*=194	N*=206	N*=216	N*=222	N*=227		
	Everyday	19.6%	30.7%	17.3%	29.0%	21.9%	21.6%	13.6%	20.4%	21.3%	21.9%	13.6%	12.4%	24.7%	22.3%	21.8%	25.7%		
	Some days	3.7%	6.7%	4.2%	4.7%	5.1%	6.7%	5.0%	5.6%	11.0%	7.5%	8.3%	5.2%	3.6%	7.8%	7.9%	1.6%		
	Not at all	76.7%	62.6%	78.5%	66.4%	72.2%	71.2%	80.7%	74.0%	67.6%	70.5%	78.2%	82.5%	71.7%	68.9%	70.4%	72.1%		
Not asked /Refused	0.0%	0.0%	0.0%	0.0%	0.7%	0.6%	0.7%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.9%	0.0%	0.6%			

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996 and 1998.

Data Table 29. Responses to BRFSS Questions about Environmental Tobacco Smoke Exposure, Nashville, TN, 1998

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998 NONSMOKERS ONLY																			
During the past 30 days, have you been exposed to secondhand smoke?		N*=2356	N*=1056	N*=1301	N*=1760	N*=554	N*=43	N*=1165	N*=1187	N*=331	N*=508	N*=470	N*=388	N*=241	N*=418	N*=220	N*=659	N*=618	N*=859
	Yes	62.6%	66.3%	59.6%	62.6%	62.6%	63.1%	60.6%	64.7%	76.3%	72.3%	66.4%	67.5%	53.8%	36.1%	54.8%	63.8%	61.8%	64.2%
	No	36.4%	32.3%	39.7%	36.3%	36.5%	35.8%	38.0%	34.7%	23.7%	27.2%	33.1%	30.8%	43.3%	62.4%	43.8%	35.0%	37.2%	34.9%
	Don't Know	0.9%	1.4%	0.6%	1.0%	0.8%	0.0%	1.3%	0.6%	0.0%	0.5%	0.3%	1.6%	2.9%	1.1%	0.6%	1.2%	1.0%	0.8%
	Refused	0.1%	0.0%	0.2%	0.1%	0.1%	1.1%	0.1%	0.1%	0.0%	0.0%	0.2%	0.0%	0.0%	0.4%	0.7%	0.0%	0.0%	0.1%
In which settings are you exposed? (choose al that apply)																			
	Home	14.5%	12.7%	16.0%	13.4%	18.0%	17.5%	11.7%	17.3%	24.0%	14.5%	11.7%	16.9%	13.5%	8.7%	22.9%	19.8%	15.9%	7.3%
	Work	18.2%	24.6%	13.2%	17.1%	21.9%	18.7%	17.2%	19.3%	24.5%	23.4%	231.0%	19.4%	13.6%	3.1%	10.6%	21.2%	21.2%	15.8%
	Restaurant	32.6%	36.0%	29.9%	35.8%	22.4%	33.6%	33.0%	32.3%	32.6%	39.2%	35.5%	37.7%	28.1%	19.1%	13.6%	28.8%	30.4%	42.0%
	Other	12.8%	12.6%	12.9%	11.9%	15.5%	125.0%	11.5%	14.0%	19.9%	16.3%	10.6%	12.7%	8.3%	7.8%	13.4%	11.4%	14.0%	12.8%
	Don't Know	0.3%	0.6%	0.1%	0.4%	0.0%	0.0%	0.4%	0.2%	0.0%	0.3%	0.3%	0.2%	0.6%	0.7%	0.0%	0.5%	0.1%	0.4%
	Refused	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.1%
Planning Districts																			
Question	Response	Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage		
1998 NONSMOKERS ONLY																			
During the past 30 days, have you been exposed to secondhand smoke?		N*=140	N*=129	N*=156	N*=132	N*=141	N*=149	N*=164	N*=152	N*=121	N*=132	N*=161	N*=160	N*=148	N*=151	N*=157	N*=165		
	Yes	63.8%	66.6%	54.1%	63.5%	58.2%	61.9%	52.8%	59.3%	61.0%	66.7%	61.0%	65.4%	66.8%	68.5%	66.1%	67.0%		
	No	35.7%	33.4%	44.7%	34.8%	40.8%	37.6%	45.7%	40.7%	38.0%	32.1%	37.5%	33.3%	33.1%	29.9%	31.4%	32.1%		
	Don't Know	0.5%	0.0%	1.1%	1.2%	1.0%	0.5%	0.6%	0.0%	1.1%	1.1%	1.5%	1.3%	0.0%	1.6%	2.4%	0.8%		
	Refused	0.0%	0.0%	0.0%	0.5%	0.1%	0.0%	0.9%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%		
In which settings are you exposed? (choose al that apply)																			
	Home	18.8%	21.5%	13.7%	16.7%	13.6%	9.3%	6.8%	8.4%	23.0%	24.1%	10.9%	8.2%	14.6%	16.4%	19.3%	12.9%		
	Work	18.6%	22.6%	17.9%	23.2%	17.8%	14.5%	8.5%	19.0%	14.2%	22.3%	11.3%	12.3%	23.0%	20.0%	23.7%	24.7%		
	Restaurant	26.3%	28.8%	27.7%	31.4%	20.5%	33.5%	40.9%	33.3%	19.7%	22.4%	35.0%	42.8%	32.1%	36.4%	41.2%	41.2%		
	Other	13.1%	10.6%	7.5%	15.1%	17.6%	18.1%	5.9%	11.1%	20.1%	15.1%	13.9%	13.1%	14.3%	14.3%	11.7%	6.2%		
	Don't Know	1.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	1.4%	0.9%	0.0%	0.0%	0.5%		
	Refused	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1998.

Data Table 30. Responses to BRFSS Questions about Sexual Behavior Change, Nashville, TN, 1996

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1996																			
Due to what you know about HIV, have you changed your sexual behavior in the last 12 months?		N=2802	N=1293	N=1509	N=2133	N=617	N=52	N=1296	N=1505	N=388	N=642	N=614	N=447	N=295	N=416	N=394	N=875	N=697	N=836
	Yes	18.1%	21.5%	15.1%	13.4%	34.3%	16.2%	4.7%	29.6%	34.9%	21.9%	20.7%	16.3%	9.3%	0.8%	13.5%	23.1%	19.9%	13.5%
	No	67.4%	67.3%	67.5%	70.7%	55.3%	75.2%	82.8%	54.2%	64.6%	76.4%	78.0%	80.9%	87.3%	12.0%	58.2%	62.5%	67.7%	76.6%
	Don't know	0.6%	0.3%	0.9%	0.6%	0.5%	1.3%	0.6%	0.6%	0.5%	0.8%	0.3%	0.9%	0.8%	0.3%	0.6%	0.8%	0.5%	0.4%
	Not asked	13.1%	10.4%	15.4%	14.4%	9.4%	3.3%	11.4%	14.5%	0.0%	0.2%	0.0%	0.8%	0.6%	86.5%	27.4%	12.9%	10.7%	8.6%
Refused	0.9%	0.5%	1.1%	0.9%	0.5%	4.0%	0.5%	1.1%	0.0%	0.8%	1.0%	1.1%	2.0%	0.4%	0.4%	0.6%	1.2%	1.0%	
1996 Respondents who reported sexual behavior change																			
Have you had sexual intercourse with only one partner?		N=506	N=278	N=228	N=286	N=212	N=8	N=61	N=445	N=135	N=140	N=127	N=73	N=27	N=3	N=53	N=202	N=139	N=113
	Yes	69.5%	66.8%	72.7%	66.4%	73.7%	66.5%	68.9%	67.1%	66.8%	72.7%	70.6%	71.5%	55.9%	65.8%	69.1%	71.6%	66.2%	69.8%
	No	24.0%	27.5%	19.6%	27.6%	18.7%	33.5%	8.5%	26.1%	31.1%	21.6%	22.0%	17.7%	25.0%	34.2%	19.7%	21.5%	29.1%	23.9%
	Don't know	1.6%	1.0%	2.3%	1.5%	1.7%	0.0%	2.0%	1.5%	0.0%	2.5%	1.2%	2.3%	4.5%	0.0%	2.6%	2.0%	0.6%	1.6%
	Not asked	2.6%	2.4%	3.0%	2.3%	3.2%	0.0%	2.6%	2.7%	1.5%	2.0%	4.3%	1.9%	6.4%	0.0%	3.3%	1.8%	2.0%	4.7%
Refused	2.4%	2.4%	2.4%	2.2%	2.7%	0.0%	0.0%	2.7%	0.6%	1.2%	1.9%	6.7%	8.3%	0.0%	5.3%	3.2%	2.1%	0.0%	
Have you used condoms for protection?		N=506	N=278	N=228	N=286	N=212	N=8	N=61	N=445	N=135	N=140	N=127	N=73	N=27	N=3	N=53	N=202	N=139	N=113
	Yes	67.5%	70.1%	64.4%	64.3%	70.6%	100.0%	47.9%	70.2%	80.2%	71.3%	59.9%	58.4%	48.9%	34.2%	63.6%	68.1%	64.9%	71.5%
	No	27.1%	26.7%	27.6%	31.5%	22.3%	0.0%	45.2%	24.7%	17.7%	24.2%	33.1%	33.4%	40.2%	65.8%	26.0%	27.0%	32.1%	21.8%
	Don't know	1.5%	0.4%	2.9%	1.3%	2.0%	0.0%	2.9%	1.4%	0.0%	2.5%	0.7%	3.0%	4.5%	0.0%	2.6%	1.7%	0.6%	2.0%
	Not asked	2.6%	2.4%	3.0%	2.3%	3.2%	0.0%	2.6%	2.7%	1.5%	2.0%	4.3%	1.9%	6.4%	0.0%	3.3%	1.8%	2.0%	4.7%
Refused	1.2%	0.4%	2.1%	0.6%	2.0%	0.0%	1.5%	1.1%	0.6%	0.0%	2.1%	3.3%	0.0%	0.0%	4.5%	1.5%	0.4%	0.0%	

Question	Response	Planning Districts													
		Joelton	Belshire/ Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts- ville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Wood- bine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1996															
Due to what you know about HIV, have you changed your sexual behavior in the last 12 months?		N=176	N=200	N=189	N=215	N=190	N=208	N=219	N=174	N=179	N=199	N=206	N=213	N=218	N=216
	Yes	18.5%	21.4%	20.8%	16.7%	20.4%	13.3%	14.2%	29.9%	22.6%	18.0%	15.0%	16.7%	20.6%	8.7%
	No	73.1%	67.9%	61.3%	69.9%	62.5%	67.0%	71.3%	54.4%	61.0%	61.5%	71.1%	71.8%	71.5%	75.4%
	Don't know	0.9%	0.3%	0.4%	0.3%	0.8%	1.5%	0.6%	0.0%	1.4%	1.8%	0.0%	0.5%	0.0%	0.0%
	Not asked	7.1%	10.4%	16.7%	12.8%	14.7%	15.7%	12.5%	15.3%	14.1%	18.8%	12.6%	10.0%	7.2%	15.9%
Refused	0.5%	0.0%	0.7%	0.4%	1.7%	2.6%	1.5%	0.4%	0.9%	0.0%	1.4%	1.1%	0.7%	0.0%	
1996 Respondents who reported sexual behavior change															
Have you had sexual intercourse with only one partner?		N=33	N=43	N=39	N=36	N=39	N=28	N=31	N=52	N=41	N=36	N=31	N=36	N=45	N=19
	Yes	87.0%	61.3%	80.8%	68.7%	81.4%	76.0%	43.4%	69.0%	70.3%	78.2%	74.8%	61.1%	57.8%	62.2%
	No	10.5%	31.2%	12.3%	27.2%	12.7%	14.5%	44.4%	22.3%	20.6%	21.8%	17.2%	36.5%	37.3%	23.4%
	Don't know	0.0%	5.9%	2.9%	2.2%	0.0%	3.4%	4.3%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Not asked	2.5%	0.0%	4.0%	1.9%	0.0%	6.1%	0.0%	4.1%	6.5%	0.0%	8.0%	2.4%	1.2%	0.0%
Refused	0.0%	1.6%	0.0%	0.0%	0.0%	5.9%	0.0%	7.9%	2.3%	2.6%	0.0%	0.0%	3.7%	14.4%	
Have you used condoms for protection?		N=33	N=43	N=39	N=36	N=39	N=28	N=31	N=52	N=41	N=36	N=31	N=36	N=45	N=19
	Yes	65.1%	68.3%	60.5%	73.2%	68.4%	59.0%	74.5%	68.0%	65.1%	82.2%	65.0%	72.5%	63.0%	54.7%
	No	28.0%	29.5%	32.6%	22.7%	27.1%	31.5%	16.6%	24.0%	25.8%	17.8%	27.0%	25.1%	35.9%	40.9%
	Don't know	1.6%	2.2%	2.9%	2.2%	0.0%	3.4%	7.2%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Not asked	2.5%	0.0%	4.0%	1.9%	0.0%	6.1%	0.0%	4.1%	6.5%	0.0%	8.0%	2.4%	1.2%	0.0%
Refused	2.7%	0.0%	0.0%	0.0%	4.5%	0.0%	1.7%	1.6%	2.6%	0.0%	0.0%	0.0%	0.0%	4.5%	

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996.

Data Table 31. Responses to BRFSS Questions about Sexual Behavior Change, Nashville, TN, 1998

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998																			
Due to what you know about HIV, have you changed your sexual behavior in the past 12 months?		N=3230	N*=1488	N*=1742	N*=2447	N*=722	N*=61	N*=1499	N*=1724	N*=438	N*=702	N*=726	N*=549	N*=337	N*=478	N*=369	N*=983	N*=843	N*=1035
	Yes	16.0%	18.0%	14.3%	12.0%	29.8%	14.5%	3.6%	26.8%	33.1%	22.8%	15.1%	11.4%	7.2%	3.2%	17.1%	18.7%	17.9%	11.6%
	No	82.2%	80.3%	83.7%	86.4%	67.7%	83.1%	95.1%	71.0%	64.9%	76.5%	83.4%	87.5%	91.7%	91.8%	78.1%	79.2%	80.8%	87.6%
	Don't know	0.2%	0.2%	0.2%	0.2%	0.1%	0.0%	0.1%	0.3%	0.5%	0.2%	0.0%	0.2%	0.0%	0.4%	0.6%	0.1%	0.0%	0.2%
	Refused	1.6%	1.5%	1.8%	1.4%	2.5%	2.4%	1.2%	1.9%	1.6%	0.6%	1.5%	0.9%	1.1%	4.6%	4.2%	2.0%	1.4%	0.6%
1998 Respondents who reported sexual behavior change																			
Do you now always have sexual intercourse with only the same partner?		N*=517	N*=268	N*=249	N*=293	N*=215	N*=9	N*=54	N*=463	N*=145	N*=160	N*=109	N*=63	N*=24	N*=15	N*=63	N*=183	N*=151	N*=120
	Yes	63.8%	62.9%	64.8%	60.7%	67.5%	78.9%	91.2%	60.6%	67.4%	67.6%	57.7%	62.9%	53.8%	54.3%	70.2%	68.5%	63.9%	53.2%
	Abstinent	21.5%	16.0%	27.4%	22.6%	20.6%	7.1%	5.2%	23.4%	22.5%	16.1%	23.4%	26.7%	30.7%	19.2%	16.9%	19.1%	24.0%	24.6%
	No /Don't Know/ Refused	14.7%	21.1%	7.8%	16.7%	11.9%	14.0%	3.7%	15.9%	10.0%	16.3%	19.0%	10.4%	15.6%	26.5%	12.9%	12.4%	12.1%	22.2%
Do you now always use condoms for protection?		N*=517	N*=268	N*=249	N*=293	N*=215	N*=9	N*=54	N*=463	N*=145	N*=160	N*=109	N*=63	N*=24	N*=15	N*=63	N*=183	N*=151	N*=120
	Yes	47.9%	56.7%	38.5%	44.3%	51.8%	70.9%	31.7%	49.8%	53.5%	51.4%	44.6%	38.7%	37.4%	35.8%	36.1%	50.0%	43.0%	57.0%
	Abstinent	20.2%	14.4%	26.5%	21.7%	18.7%	7.1%	5.2%	22.0%	21.6%	13.4%	23.6%	24.6%	30.7%	19.2%	16.9%	18.1%	23.1%	21.6%
	No /Don't Know/ Refused	31.9%	28.9%	35.1%	33.9%	29.5%	22.0%	63.2%	28.2%	24.9%	35.2%	31.7%	36.8%	31.9%	45.0%	47.0%	31.9%	33.9%	21.5%

Question	Response	Planning Districts															
		Joelton	Belshire/ Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts- ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/ West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Wood- bine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1998		N*=182	N*=206	N*=199	N*=198	N*=193	N*=208	N*=202	N*=205	N*=179	N*=187	N*=206	N*=194	N*=206	N*=216	N*=222	N*=227
Due to what you know about HIV, have you changed your sexual behavior in the past 12 months?																	
	Yes	14.8%	16.5%	11.8%	16.6%	17.1%	15.7%	5.7%	11.7%	26.7%	27.7%	11.9%	11.4%	16.8%	20.0%	20.1%	13.1%
	No	81.2%	82.6%	86.0%	82.7%	81.1%	81.1%	92.3%	86.4%	69.4%	71.2%	86.9%	87.9%	81.1%	78.6%	79.1%	85.2%
	Don't know	1.3%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.4%	0.0%	0.0%	0.5%	0.3%	0.0%	0.0%	0.0%	0.3%
	Refused	2.7%	0.9%	2.2%	0.7%	1.9%	2.9%	2.0%	1.6%	3.9%	1.1%	0.7%	0.5%	2.1%	1.4%	0.8%	1.3%
1998 Respondents who reported sexual behavior change																	
Do you now always have sexual intercourse with only the same partner?		N*=27	N*=34	N*=23	N*=33	N*=33	N*=33	N*=12	N*=24	N*=48	N*=52	N*=25	N*=22	N*=35	N*=43	N*=45	N*=30
	Yes	60.4%	78.3%	37.7%	69.8%	65.1%	49.1%	52.1%	56.4%	78.8%	68.1%	68.2%	62.8%	58.7%	66.7%	64.5%	56.5%
	Abstinent	21.0%	20.0%	36.2%	12.6%	23.4%	31.3%	39.0%	32.1%	18.4%	16.1%	19.3%	3.7%	21.2%	25.0%	23.1%	16.4%
	No /Don't Know/ Refused	18.6%	1.7%	26.2%	17.6%	11.5%	19.7%	8.9%	11.6%	2.8%	15.9%	12.6%	33.6%	20.0%	8.4%	12.4%	27.1%
Do you now always use condoms for protection?		N*=27	N*=34	N*=23	N*=33	N*=33	N*=33	N*=12	N*=24	N*=48	N*=52	N*=25	N*=22	N*=35	N*=43	N*=45	N*=30
	Yes	38.4%	46.0%	46.0%	46.6%	62.3%	49.1%	31.8%	36.2%	47.7%	59.6%	37.5%	51.8%	28.8%	54.3%	54.9%	48.2%
	Abstinent	14.1%	20.0%	36.2%	12.6%	23.4%	31.3%	39.0%	32.1%	18.4%	16.1%	19.3%	0.0%	21.2%	21.0%	20.9%	12.0%
	No /Don't Know/ Refused	47.5%	34.0%	17.9%	40.8%	14.3%	19.7%	29.2%	31.8%	33.8%	24.4%	43.3%	48.2%	50.0%	24.7%	24.3%	39.8%

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1998.

Data Table 32. Responses to BRFSS Questions about Safety Belt Use, Nashville, TN, 1996

			Gender		Race		Marital Status			Age Group						Highest Level of Education				
Question	Response	Total	Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree	
1996																				
How often do you use seatbelts?		N=2802	N=1293	N=1509	N=2133	N=617	N=52	N=1296	N=1505	N=388	N=642	N=614	N=447	N=295	N=416	N=394	N=875	N=697	N=836	
	Always	65.6%	58.1%	72.1%	68.3%	55.6%	75.0%	70.6%	61.3%	56.1%	64.5%	68.2%	65.9%	66.2%	71.7%	51.8%	60.1%	66.0%	77.6%	
	Nearly Always	11.8%	14.2%	9.8%	11.6%	12.8%	10.4%	11.9%	11.7%	11.5%	13.1%	10.8%	12.9%	10.3%	11.6%	13.9%	12.1%	11.7%	10.7%	
	Sometimes	10.8%	13.6%	8.4%	9.5%	15.4%	8.3%	8.5%	12.7%	20.5%	11.0%	8.6%	8.7%	8.9%	8.3%	14.9%	13.7%	10.4%	6.1%	
	Seldom	4.5%	5.1%	4.0%	4.0%	6.6%	2.2%	3.7%	5.3%	5.2%	5.3%	3.7%	5.2%	4.8%	3.1%	6.9%	4.4%	5.7%	2.6%	
	Never	6.8%	8.6%	5.3%	6.3%	8.8%	4.0%	5.1%	8.3%	6.8%	6.3%	8.0%	6.9%	9.1%	4.2%	10.6%	9.6%	5.8%	2.9%	
	Don't Know	0.4%	0.3%	0.4%	0.2%	0.8%	0.0%	0.2%	0.5%	0.0%	0.0%	0.6%	0.2%	0.6%	0.9%	1.7%	0.1%	0.0%	0.2%	
	Never Ride in Car	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	
Refused	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.2%	0.1%	0.0%	0.1%	0.0%		
How often do children under 5 years use car safety seats?		N=372	N=131	N=241	N=271	N=94	N=7	N=241	N=131	N=94	N=160	N=86	N=21	N=8	N=2	N=51	N=129	N=95	N=97	
	Always	88.1%	87.1%	88.7%	89.4%	84.1%	90.4%	89.1%	86.3%	91.8%	88.7%	83.2%	85.6%	90.4%	100.0%	87.8%	89.9%	83.2%	90.7%	
	Nearly Always	3.3%	1.8%	4.2%	2.8%	4.3%	9.6%	3.3%	3.4%	2.3%	3.2%	3.6%	5.2%	9.6%	0.0%	2.6%	3.9%	2.8%	3.4%	
	Sometimes	1.8%	0.0%	2.8%	0.3%	6.2%	0.0%	0.6%	4.0%	2.6%	1.0%	1.8%	5.2%	0.0%	0.0%	1.0%	3.1%	1.4%	0.8%	
	Seldom	0.4%	1.2%	0.0%	0.6%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.6%	
	Never	5.6%	9.2%	3.7%	6.5%	3.4%	0.0%	5.6%	5.6%	3.4%	6.6%	7.3%	4.1%	0.0%	0.0%	6.8%	3.1%	10.6%	3.4%	
	Don't Know	0.2%	0.0%	0.3%	0.0%	0.9%	0.0%	0.0%	0.6%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.0%	
	Never Ride in Car	0.5%	0.8%	0.4%	0.3%	1.1%	0.0%	0.8%	0.0%	0.0%	0.0%	2.3%	0.0%	0.0%	0.0%	1.8%	0.0%	1.1%	0.0%	
How often do children between the ages of 5 and 16 use seatbelts?		N=710	N=265	N=445	N=481	N=210	N=19	N=448	N=263	N=82	N=217	N=286	N=96	N=20	N=8	N=107	N=243	N=169	N=192	
	Always	75.3%	74.2%	76.0%	79.1%	65.8%	84.4%	78.0%	70.8%	71.4%	76.1%	77.2%	87.4%	94.3%	60.2%	72.5%	79.5%	83.7%		
	Nearly Always	10.4%	12.9%	8.9%	9.9%	12.3%	3.0%	10.8%	9.8%	9.4%	8.6%	10.3%	16.1%	12.6%	0.0%	10.8%	11.9%	8.1%	10.4%	
	Sometimes	7.2%	7.7%	7.0%	6.4%	9.8%	0.0%	7.0%	7.6%	8.8%	7.9%	7.0%	6.7%	0.0%	5.7%	15.5%	7.0%	8.1%	2.2%	
	Seldom	2.2%	0.4%	3.3%	1.6%	3.4%	4.0%	0.9%	4.4%	2.7%	3.0%	1.0%	4.3%	0.0%	0.0%	3.8%	3.7%	0.7%	0.8%	
	Never	4.0%	3.6%	4.2%	3.0%	6.3%	3.1%	2.4%	6.6%	5.7%	4.4%	3.3%	4.6%	0.0%	0.0%	8.4%	4.2%	2.4%	2.6%	
	Don't Know	0.1%	0.0%	0.2%	0.0%	0.3%	0.0%	0.0%	0.3%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	
	Never Ride in Car	0.7%	1.2%	0.4%	0.0%	1.8%	5.6%	0.7%	0.6%	2.0%	0.0%	0.8%	1.1%	0.0%	0.0%	0.8%	0.8%	1.3%	0.0%	
Refused	0.1%	0.0%	0.2%	0.0%	0.3%	0.0%	0.2%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%		
Planning Districts																				
	Question	Response	Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodlettsville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crivie Hall	Priest Lake/ Antioch	Donelson/ Hermitage				
	1996																			
	How often do you use seatbelts?		N=176	N=200	N=189	N=215	N=190	N=208	N=219	N=174	N=179	N=199	N=206	N=213	N=218	N=216				
		Always	64.9%	58.9%	59.1%	65.4%	56.3%	76.5%	68.6%	53.0%	53.2%	77.7%	70.8%	66.8%	74.1%	68.0%				
		Nearly Always	10.9%	16.5%	13.5%	9.9%	17.9%	8.2%	13.0%	13.7%	13.8%	9.2%	10.3%	9.4%	8.7%	11.8%				
		Sometimes	9.8%	9.4%	13.0%	14.9%	15.5%	4.6%	11.0%	13.0%	14.7%	4.7%	11.1%	13.1%	9.2%	8.2%				
		Seldom	5.5%	7.6%	3.3%	2.1%	2.7%	2.0%	2.3%	10.4%	6.4%	4.3%	3.9%	4.2%	4.8%	5.2%				
		Never	8.6%	7.3%	11.2%	7.7%	7.0%	8.1%	4.7%	8.2%	10.2%	4.1%	3.4%	6.5%	2.8%	6.9%				
		Don't Know	0.0%	0.4%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				
		Never Ride in Car	0.4%	0.0%	0.0%	0.0%	0.6%	0.0%	0.4%	1.5%	1.7%	0.0%	0.2%	0.0%	0.5%	0.0%				
	Refused	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%					
	How often do children under 5 years use car safety seats?		N=14	N=31	N=35	N=29	N=31	N=25	N=24	N=30	N=19	N=29	N=34	N=20	N=32	N=19				
		Always	100.0%	92.0%	79.8%	84.9%	93.1%	82.7%	82.6%	78.2%	90.8%	97.7%	86.1%	100.0%	84.3%	95.0%				
		Nearly Always	0.0%	2.6%	4.2%	2.2%	1.7%	0.0%	17.4%	5.0%	0.0%	2.3%	0.0%	0.0%	7.8%	0.0%				
		Sometimes	0.0%	0.0%	4.6%	3.1%	0.0%	0.0%	0.0%	11.4%	4.4%	0.0%	0.0%	0.0%	0.0%	0.0%				
		Seldom	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%				
		Never	0.0%	5.4%	11.3%	9.8%	2.7%	13.0%	0.0%	5.5%	0.0%	0.0%	13.9%	0.0%	3.0%	5.0%				
		Don't Know	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	0.0%	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%				
Never Ride in Car		0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					
How often do children between the ages of 5 and 16 use seatbelts?		N=44	N=79	N=46	N=59	N=59	N=45	N=47	N=33	N=55	N=38	N=55	N=51	N=49	N=50					
	Always	72.0%	81.6%	67.2%	76.0%	68.6%	77.3%	74.3%	51.8%	59.9%	92.7%	80.9%	77.7%	84.2%	84.1%					
	Nearly Always	9.1%	3.8%	22.1%	7.9%	14.8%	3.5%	15.9%	7.0%	17.5%	2.4%	14.4%	2.5%	12.6%	12.5%					
	Sometimes	13.7%	9.0%	5.0%	9.9%	9.9%	9.6%	0.0%	21.6%	10.2%	2.1%	1.3%	9.1%	0.0%	1.8%					
	Seldom	0.0%	4.5%	0.0%	1.4%	4.7%	1.9%	2.0%	9.7%	5.2%	0.0%	0.0%	1.3%	0.0%	0.0%					
	Never	3.7%	0.0%	5.7%	2.9%	2.1%	7.7%	6.0%	9.8%	6.0%	0.0%	1.5%	9.4%	3.1%	1.7%					
	Don't Know	0.0%	1.0%	0.0%	1.8%	0.0%	0.0%	1.7%	0.0%	0.0%	2.8%	2.0%	0.0%	0.0%	0.0%					
	Never Ride in Car	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%					
Refused	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996.

Data Table 33. Responses to BRFSS Questions about Safety Belt Use, Nashville, TN, 1998

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998																			
How often do you use seatbelts?		N=3230	N*=1488	N*=1742	N*=2447	N*=722	N*=61	N*=1499	N*=1724	N*=438	N*=702	N*=726	N*=549	N*=337	N*=478	N*=369	N*=983	N*=843	N*=1035
	Always	68.2%	61.6%	73.8%	71.4%	56.9%	72.2%	75.5%	61.9%	55.6%	66.9%	68.4%	70.7%	70.0%	77.0%	54.4%	61.8%	68.8%	78.6%
	Nearly Always	13.4%	16.3%	10.9%	13.3%	14.1%	10.7%	12.3%	14.3%	16.8%	13.4%	13.6%	14.1%	12.7%	9.5%	13.8%	13.9%	13.7%	12.5%
	Sometimes	8.2%	9.2%	7.4%	7.1%	12.3%	5.3%	5.4%	10.7%	14.4%	8.3%	9.0%	5.1%	7.5%	5.3%	14.4%	11.6%	6.7%	4.1%
	Seldom	3.7%	4.0%	3.5%	3.2%	5.7%	2.2%	2.4%	4.9%	5.4%	4.2%	3.5%	3.6%	3.6%	2.1%	4.2%	4.2%	5.1%	1.9%
	Never	6.1%	8.6%	3.9%	4.8%	10.2%	8.3%	4.3%	7.6%	7.5%	7.0%	5.5%	6.5%	5.5%	4.2%	11.8%	8.0%	5.4%	2.7%
	Don't Know	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.2%	0.4%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%	0.1%	0.0%
	Never Ride in Car	0.4%	0.3%	0.5%	0.2%	0.8%	0.9%	0.2%	0.5%	0.0%	0.2%	0.1%	0.1%	0.7%	1.5%	1.3%	0.3%	0.2%	0.2%
	Refused	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
How often do children under 5 years use safety seats or children older than 5 years, but younger than 16, use seatbelts?		N*=986	N*=389	N*=597	N*=665	N*=295	N*=26	N*=605	N*=380	N*=161	N*=320	N*=340	N*=122	N*=28	N*=15	N*=112	N*=328	N*=262	N*=284
	Always	84.8%	87.5%	83.0%	87.5%	78.1%	89.9%	88.9%	78.1%	83.0%	84.8%	86.8%	83.0%	81.9%	75.8%	79.2%	82.3%	81.5%	92.8%
	Nearly Always	7.6%	6.2%	8.5%	6.1%	11.2%	4.9%	6.2%	9.9%	6.7%	8.9%	6.5%	8.4%	6.5%	9.8%	8.5%	7.4%	10.4%	5.0%
	Sometimes	4.8%	4.0%	5.3%	3.8%	7.3%	3.2%	3.1%	7.5%	5.9%	3.5%	4.7%	5.7%	11.6%	3.4%	7.0%	7.8%	4.0%	1.2%
	Seldom	1.2%	1.0%	1.4%	1.1%	1.5%	2.1%	1.2%	1.3%	1.1%	1.1%	1.3%	1.1%	0.0%	7.6%	0.8%	1.0%	1.9%	1.0%
	Never	0.8%	0.3%	1.1%	0.8%	0.9%	0.0%	0.4%	1.5%	1.0%	1.0%	0.3%	1.8%	0.0%	0.0%	1.9%	0.7%	1.3%	0.0%
	Don't Know	0.6%	1.0%	0.3%	0.6%	0.7%	0.0%	0.2%	1.1%	2.3%	0.4%	0.2%	0.0%	0.0%	0.0%	2.1%	0.6%	0.5%	0.0%
	Never Ride in Car	0.2%	0.0%	0.3%	0.0%	0.5%	0.0%	0.0%	0.4%	0.0%	0.3%	0.0%	0.0%	0.0%	3.4%	0.4%	0.0%	0.4%	0.0%
	Refused	0.1%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Question	Response	Joelton	Planning Districts																
			Belshire / Union Hill	Bordeaux / Whites Creek	Madison / Goodletts-ville	East Nashville / Inglewood	Bellevue	The Nations / Sylvan Park	Belle Meade / West Meade	North Nashville	Downtown	West End / Vanderbilt	Forest Hills / Oak Hill	Berry Hill / Woodbine	Tusculum / Crieve Hall	Priest Lake / Antioch	Donelson / Hermitage		
1998																			
How often do you use seatbelts?		N*=182	N*=206	N*=199	N*=198	N*=193	N*=208	N*=202	N*=205	N*=179	N*=187	N*=206	N*=194	N*=206	N*=216	N*=222	N*=227		
	Always	61.6%	60.0%	60.6%	68.1%	63.8%	77.8%	75.5%	76.1%	59.8%	54.5%	79.8%	73.5%	67.4%	69.7%	66.3%	72.1%		
	Nearly Always	15.0%	13.5%	15.8%	12.0%	14.9%	11.6%	13.9%	14.2%	12.9%	20.4%	7.5%	14.6%	16.3%	11.3%	11.8%	10.0%		
	Sometimes	9.3%	14.2%	8.9%	10.4%	9.4%	6.1%	3.7%	4.7%	11.5%	9.3%	7.1%	3.4%	6.5%	8.6%	10.9%	7.8%		
	Seldom	4.3%	6.3%	3.9%	4.4%	6.4%	1.8%	2.7%	1.2%	7.7%	3.9%	1.1%	2.5%	2.8%	5.0%	3.6%	2.8%		
	Never	9.8%	5.5%	10.3%	4.0%	5.4%	2.0%	3.6%	3.4%	5.8%	11.2%	4.6%	5.7%	6.8%	5.4%	7.1%	7.1%		
	Don't Know	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
	Never Ride in Car	0.0%	0.6%	0.4%	0.4%	0.0%	0.8%	0.6%	0.0%	2.3%	0.7%	0.0%	0.3%	0.2%	0.0%	0.2%	0.0%		
	Refused	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
How often do children under 5 years use safety seats or children older than 5 years, but younger than 16, use seatbelts?		N*=73	N*=83	N*=69	N*=60	N*=69	N*=63	N*=43	N*=52	N*=52	N*=71	N*=47	N*=42	N*=62	N*=60	N*=59	N*=81		
	Always	77.5%	84.8%	78.1%	82.9%	77.4%	94.8%	89.6%	96.8%	80.2%	80.2%	89.0%	92.5%	87.5%	81.3%	80.7%	90.5%		
	Nearly Always	9.8%	6.1%	9.8%	6.0%	9.4%	0.0%	8.1%	3.2%	9.5%	9.1%	4.3%	2.8%	9.5%	12.5%	15.4%	4.7%		
	Sometimes	8.2%	5.6%	7.6%	11.1%	9.5%	0.0%	2.3%	0.0%	9.3%	6.3%	5.5%	0.0%	0.0%	3.2%	4.0%	1.3%		
	Seldom	1.4%	2.4%	1.9%	0.0%	1.9%	1.5%	0.0%	0.0%	1.0%	1.4%	0.0%	4.7%	3.0%	0.0%	0.0%	0.0%		
	Never	0.0%	1.1%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	1.1%	0.0%	0.0%	3.0%	0.0%	3.6%		
	Don't Know	1.8%	0.0%	0.0%	0.0%	1.9%	3.7%	0.0%	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
	Never Ride in Car	0.0%	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
	Refused	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1998.

Data Table 34. Responses to BRFSS Questions about Bicycle Helmet Use in Children, Nashville, TN, 1996

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1996																			
During the past year, how often has the ... child worn a bicycle helmet when riding a bicycle?		N*=723	N*=272	N*=450	N*=488	N*=214	N*=20	N*=456	N*=266	N*=86	N*=224	N*=288	N*=98	N*=19	N*=8	N*=107	N*=244	N*=180	N*=191
	Always	31.0%	28.9%	32.3%	33.6%	24.8%	34.8%	34.7%	24.7%	22.7%	32.5%	33.9%	25.5%	27.9%	47.8%	24.6%	26.4%	33.5%	38.0%
	Nearly Always	4.8%	4.4%	4.9%	5.9%	1.9%	7.5%	6.3%	2.2%	1.0%	4.7%	5.0%	7.6%	2.1%	8.4%	0.6%	4.4%	5.8%	6.5%
	Sometimes	9.9%	9.0%	10.4%	9.6%	9.6%	18.7%	10.6%	8.5%	10.3%	12.8%	6.7%	11.8%	14.7%	0.0%	10.8%	11.2%	7.4%	10.0%
	Seldom	5.6%	5.6%	5.7%	5.2%	7.1%	0.0%	6.0%	5.0%	4.6%	5.9%	6.3%	3.3%	8.9%	6.2%	5.6%	6.1%	6.6%	4.2%
	Never	21.7%	24.5%	20.1%	20.2%	26.5%	8.8%	19.9%	24.9%	23.8%	21.2%	21.4%	24.5%	12.5%	14.6%	19.6%	26.8%	17.6%	20.4%
	Never Rides a Bike	25.8%	26.6%	25.3%	24.4%	28.6%	30.2%	21.2%	33.6%	36.7%	22.0%	25.1%	25.8%	33.9%	16.8%	37.6%	24.4%	26.5%	20.2%
	Don't Know	1.2%	1.2%	1.2%	1.2%	1.2%	0.0%	1.2%	1.1%	1.0%	0.8%	1.4%	1.4%	0.0%	6.2%	1.3%	0.7%	2.6%	0.4%
	Refused	0.1%	0.0%	0.2%	0.0%	0.3%	0.0%	0.2%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%

Question	Response	Planning Districts													
		Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Down-town	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1996															
During the past year, how often has the ... child worn a bicycle helmet when riding a bicycle?		N*=45	N*=81	N*=48	N*=60	N*=61	N*=45	N*=46	N*=36	N*=54	N*=38	N*=60	N*=48	N*=49	N*=51
	Always	16.4%	26.4%	22.8%	42.7%	24.2%	38.1%	50.9%	33.6%	20.7%	54.4%	31.3%	23.2%	32.1%	26.5%
	Nearly Always	6.2%	1.7%	8.6%	11.6%	9.6%	5.7%	1.9%	4.1%	0.0%	6.7%	0.0%	3.7%	6.2%	1.8%
	Sometimes	8.4%	8.0%	17.0%	10.7%	15.2%	10.8%	11.0%	6.2%	9.4%	4.2%	7.0%	9.5%	8.5%	10.3%
	Seldom	3.9%	6.4%	3.0%	4.0%	1.5%	7.6%	5.8%	2.3%	7.4%	4.4%	8.8%	6.4%	7.1%	9.2%
	Never	35.9%	17.5%	31.4%	10.1%	29.5%	10.2%	19.6%	21.6%	28.2%	10.7%	18.6%	30.9%	20.5%	20.9%
	Never Rides a Bike	27.6%	37.1%	16.1%	16.8%	20.0%	27.7%	10.8%	29.9%	31.7%	17.5%	34.4%	26.2%	25.6%	31.3%
	Don't Know	0.0%	2.9%	1.1%	4.1%	0.0%	0.0%	0.0%	2.2%	2.6%	2.2%	0.0%	0.0%	0.0%	0.0%
	Refused	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996.

Data Table 35. Responses to BRFSS Questions about Mammography, Nashville, TN, 1996 and 1998

Question	Response	Women	Race			Marital Status		Age Group						Highest Level of Education			
			White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1996																	
Women only																	
A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?		N*=1509	N*=1134	N*=349	N*=26	708	N*=801	N*=199	N*=329	N*=317	N*=236	N*=162	N*=266	N*=255	N*=487	N*=385	N*=381
	Yes	58.2%	58.2%	58.8%	48.7%	59.9%	56.7%	16.8%	20.4%	62.1%	89.6%	92.0%	82.9%	64.3%	56.9%	56.1%	57.9%
	No	41.6%	41.4%	41.2%	51.3%	40.0%	42.9%	83.2%	79.6%	37.9%	10.4%	8.0%	15.7%	35.0%	43.0%	43.7%	41.9%
	Not Asked	0.1%	0.2%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.5%	0.0%	0.2%	0.0%
	Refused	0.1%	0.2%	0.0%	0.0%	0.1%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.3%	0.1%	0.0%	0.2%

Question	Response	Planning Districts													
		Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1996															
Women only															
A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?		N*=105	N*=113	N*=108	N*=114	N*=106	N*=121	N*=99	N*=93	N*=94	N*=100	N*=112	N*=112	N*=115	N*=116
	Yes	68.0%	52.1%	65.2%	61.0%	52.5%	66.6%	65.6%	50.2%	56.5%	57.2%	56.4%	52.4%	49.8%	60.5%
	No	32.0%	47.9%	34.2%	39.0%	46.8%	33.4%	34.4%	49.8%	43.5%	41.5%	43.6%	47.7%	49.1%	39.5%
	Not Asked	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.6%	0.0%
	Refused	0.0%	0.0%	0.6%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%

Question	Response	Women	Race			Marital Status		Age Group						Highest Level of Education			
			White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998																	
Women only																	
A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?		N*=1742	N*=1301	N*=410	N*=30	N*=811	N*=926	N*=225	N*=360	N*=377	N*=289	N*=186	N*=305	N*=216	N*=568	N*=467	N*=490
	Yes	60.9%	61.9%	58.2%	55.1%	62.6%	59.6%	17.3%	19.0%	67.3%	91.8%	91.5%	86.8%	65.8%	59.1%	61.4%	60.5%
	No	38.6%	37.6%	41.5%	43.2%	37.0%	40.0%	81.3%	80.7%	32.5%	8.2%	8.5%	12.1%	32.8%	40.4%	38.4%	39.2%
	Not sure	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
	Refused	0.4%	0.4%	0.4%	1.7%	0.3%	0.5%	1.4%	0.0%	0.3%	0.0%	0.0%	1.1%	1.4%	0.5%	0.2%	0.1%

Question	Response	Planning Districts															
		Joelton	Belshire / Union Hill	Bordeaux /Whites Creek	Madison/ Goodletts- ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/ West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1998																	
Women only																	
A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?	Yes	N*=104	N*=109	N*=103	N*=119	N*=110	N*=106	N*=95	N*=105	N*=108	N*=119	N*=97	N*=112	N*=113	N*=121	N*=94	N*=121
	No	68.4%	66.5%	61.8%	65.6%	63.5%	64.7%	69.7%	61.5%	56.4%	53.2%	65.2%	67.1%	64.1%	55.7%	50.1%	44.8%
	Not sure	31.5%	33.5%	37.3%	34.4%	36.0%	33.9%	28.1%	37.2%	43.6%	46.8%	34.8%	32.5%	35.9%	44.3%	49.9%	54.3%
	Refused	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%
		0.1%	0.0%	0.9%	0.0%	0.5%	1.5%	2.2%	1.4%	0.0%	0.1%	0.0%	0.4%	0.1%	0.0%	0.0%	0.1%

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996 and 1998.

Data Table 36. Responses to BRFSS Questions about Pap Smear Tests, Nashville, TN, 1996 and 1998

				Race				Marital Status		Age Group						Highest Level of Education			
Question	Response	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree		
1996																			
Women only																			
A Pap Smear is a test for cancer of the cervix. Have you ever had a Pap Smear?		N*=1509	N*=1134	N*=349	N*=26	708	N*=801	N*=199	N*=329	N*=317	N*=236	N*=162	N*=266	N*=255	N*=487	N*=385	N*=381		
	Yes	94.9%	95.0%	94.6%	90.7%	97.9%	92.2%	87.0%	97.8%	97.9%	97.0%	96.3%	90.8%	92.1%	94.6%	95.6%	96.3%		
	No	4.6%	4.3%	5.1%	9.3%	1.6%	7.1%	13.0%	2.3%	1.8%	2.5%	3.3%	7.1%	6.6%	4.7%	4.1%	3.6%		
	Don't know	0.1%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.5%	0.2%	0.3%	0.1%	0.0%	0.0%		
	Not Asked	0.1%	0.2%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.5%	0.0%	0.2%	0.0%		
	Refused	0.4%	0.4%	0.3%	0.0%	0.4%	0.3%	0.0%	0.0%	0.3%	0.6%	0.0%	1.2%	0.4%	0.6%	0.2%	0.2%		
		Planning Districts																	
Question	Response	Joelton	Belshire/ Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage				
1996																			
Women only																			
A Pap Smear is a test for cancer of the cervix. Have you ever had a Pap Smear?		N*=105	N*=113	N*=108	N*=114	N*=106	N*=121	N*=99	N*=93	N*=94	N*=100	N*=112	N*=112	N*=115	N*=116				
	Yes	96.5%	94.8%	90.5%	98.7%	95.3%	95.5%	97.9%	90.4%	91.3%	93.0%	97.3%	97.9%	88.9%	98.7%				
	No	3.5%	4.7%	8.9%	0.6%	3.3%	4.1%	2.1%	8.7%	8.7%	5.2%	2.7%	2.2%	9.4%	1.3%				
	Don't know	0.0%	0.6%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				
	Not Asked	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.6%	0.0%				
	Refused	0.0%	0.0%	0.6%	0.0%	1.4%	0.4%	0.0%	1.0%	0.0%	0.5%	0.0%	0.0%	1.1%	0.0%				
Question	Response		Race				Marital Status		Age Group						Highest Level of Education				
		Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree		
1998																			
Women only																			
A Pap Smear is a test for cancer of the cervix. Have you ever had a Pap Smear?		N*=1742	N*=1301	N*=410	N*=30	N*=811	N*=926	N*=225	N*=360	N*=377	N*=289	N*=186	N*=305	N*=216	N*=568	N*=467	N*=490		
	Yes	94.8%	94.6%	95.3%	94.5%	97.7%	92.2%	84.2%	97.5%	96.8%	99.0%	97.0%	91.6%	92.9%	93.3%	95.0%	97.1%		
	No	4.7%	4.8%	4.4%	3.8%	2.0%	7.1%	14.5%	2.6%	3.0%	1.0%	3.0%	6.6%	4.8%	6.3%	4.8%	2.7%		
	Not sure	0.1%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.3%	0.0%	0.0%	0.1%		
	Refused	0.5%	0.5%	0.4%	1.7%	0.3%	0.5%	1.4%	0.0%	0.3%	0.0%	0.0%	1.3%	2.1%	0.4%	0.2%	0.1%		
		Planning Districts																	
Question	Response	Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/ West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage		
1998																			
Women only																			
A Pap Smear is a test for cancer of the cervix. Have you ever had a Pap Smear?		N*=104	N*=109	N*=103	N*=119	N*=110	N*=106	N*=95	N*=105	N*=108	N*=119	N*=97	N*=112	N*=113	N*=121	N*=94	N*=121		
	Yes	97.2%	96.2%	93.0%	96.1%	94.5%	92.0%	92.4%	95.6%	97.6%	97.1%	90.1%	92.7%	95.0%	96.0%	98.3%	91.7%		
	No	2.8%	3.8%	6.1%	2.1%	5.0%	6.5%	5.3%	3.7%	2.4%	2.8%	9.9%	6.3%	4.9%	4.0%	1.7%	8.2%		
	Not sure	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%		
	Refused	0.1%	0.0%	0.9%	1.2%	0.5%	1.5%	2.2%	0.7%	0.0%	0.1%	0.0%	0.4%	0.1%	0.0%	0.0%	0.1%		

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996 and 1998.

Data Table 37. Responses to BRFSS Questions about Digital Rectal Exams, Nashville, TN, 1996 and 1998

Question	Response	Total	Gender		Race			Marital Status		Age Group				Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	40-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1996 Respondents over age 40																	
A digital rectal exam is when a doctor or other health professional inserts a finger in the rectum to check for cancer and other health problems. Have you ever had this exam?		N*=1454	N*=635	N*=819	N*=1155	N*=281	N*=18	N*=750	N*=703	N*=296	N*=448	N*=295	N*=416	N*=245	N*=444	N*=347	N*=419
	Yes	71.7%	72.7%	71.0%	72.0%	71.5%	56.9%	72.4%	71.0%	56.6%	73.3%	79.7%	75.1%	71.1%	71.0%	70.0%	74.3%
	No	25.2%	24.0%	26.0%	24.8%	26.3%	33.3%	24.2%	26.2%	34.8%	25.4%	19.4%	22.2%	25.9%	25.1%	28.0%	22.5%
	Don't Know	1.2%	1.2%	1.3%	1.2%	1.2%	4.6%	1.5%	1.0%	2.2%	1.1%	0.3%	1.4%	1.4%	2.0%	0.7%	0.9%
	Not Asked	1.7%	2.0%	1.5%	1.8%	0.9%	5.2%	1.8%	1.6%	6.5%	0.2%	0.6%	0.6%	1.6%	1.7%	1.4%	2.0%
	Refused	0.2%	0.2%	0.2%	0.2%	0.2%	0.0%	0.2%	0.2%	0.0%	0.1%	0.0%	0.6%	0.0%	0.3%	0.0%	0.4%
Planning Districts																	
Question	Response	Joelton	Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage		
1996 Respondents over age 40																	
A digital rectal exam is when a doctor or other health professional inserts a finger in the rectum to check for cancer and other health problems. Have you ever had this exam?		N*=112	N*=102	N*=113	N*=119	N*=98	N*=116	N*=133	N*=69	N*=84	N*=113	N*=108	N*=86	N*=88	N*=113		
	Yes	84.5%	78.3%	79.3%	63.6%	68.0%	74.2%	71.4%	68.7%	69.1%	68.4%	71.8%	63.4%	67.7%	71.9%		
	No	15.5%	18.3%	18.7%	31.0%	29.8%	21.2%	25.6%	30.0%	28.8%	28.2%	25.0%	30.3%	30.1%	24.2%		
	Don't Know	0.0%	0.7%	2.0%	1.3%	1.3%	2.7%	1.2%	1.3%	1.4%	0.6%	0.0%	2.6%	0.7%	1.8%		
	Not Asked	0.0%	2.8%	0.0%	4.0%	0.9%	1.4%	1.8%	0.0%	0.8%	1.9%	3.2%	3.7%	0.0%	2.2%		
	Refused	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	1.5%	0.0%		
Planning Districts																	
Question	Response	Total	Gender		Race			Marital Status		Age Group				Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	40-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998 Male Respondents over age 40																	
A digital rectal exam is when a doctor or other health professional inserts a finger in the rectum to check for cancer and other health problems. Have you ever had this exam?		N*=764	N*=764	N*=0	N*=608	N*=145	N*=12	N*=441	N*=323	N*=180	N*=260	N*=151	N*=172	N*=79	N*=222	N*=185	N*=279
	Yes	74.1%	74.1%		76.4%	64.2%	77.8%	77.3%	69.7%	62.6%	67.9%	82.4%	88.1%	68.4%	72.0%	68.3%	81.1%
	No	24.7%	24.7%		22.3%	34.9%	21.5%	22.2%	28.1%	36.6%	31.6%	15.8%	9.4%	27.1%	26.9%	30.4%	18.4%
	Don't Know	0.3%	0.3%		0.4%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	1.2%	1.4%	0.0%	0.6%	0.0%
	Refused	1.0%	1.0%		1.0%	0.9%	0.8%	0.6%	1.6%	0.8%	0.5%	1.8%	1.3%	3.2%	1.1%	0.7%	0.5%
Planning Districts																	
Question	Response	Joelton	Planning Districts					Planning Districts, Continued									
			Belshire / Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/ West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1998 Male Respondents over age 40																	
A digital rectal exam is when a doctor or other health professional inserts a finger in the rectum to check for cancer and other health problems. Have you ever had this exam?		N*=38	N*=46	N*=52	N*=41	N*=56	N*=53	N*=66	N*=51	N*=43	N*=32	N*=43	N*=59	N*=51	N*=35	N*=48	N*=50
	Yes	74.4%	65.5%	70.8%	65.9%	71.7%	69.5%	80.0%	77.4%	78.7%	63.9%	78.4%	74.3%	73.8%	77.6%	81.4%	77.0%
	No	25.6%	34.5%	26.7%	34.1%	26.4%	25.9%	20.0%	20.5%	15.1%	35.8%	21.6%	25.7%	24.1%	22.5%	18.6%	23.0%
	Don't Know	0.0%	0.0%	0.0%	0.0%	1.9%	0.0%	0.0%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Refused	0.0%	0.0%	2.5%	0.0%	0.0%	4.6%	0.0%	0.0%	0.0%	6.2%	0.3%	0.0%	0.0%	2.1%	0.0%	0.0%

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996 and 1998.

Data Table 38. Responses to BRFS Questions Regarding Health Status and Activity Limitation Days, Nashville, TN, 1996

		Gender			Race			Marital Status		Age Group					Highest Level of Education					
Question	Response	Total	Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree	
1996		N=2802	N=1293	N=1509	N=2133	N=617	N=52	N=1296	N=1505	N=388	N=642	N=614	N=448	N=295	N=416	N=394	N=875	N=697	N=836	
In general, would you say your health is:	Excellent	19.6%	19.5%	19.7%	20.7%	15.8%	18.6%	18.9%	20.2%	19.2%	22.6%	22.0%	18.1%	15.7%	16.4%	9.9%	13.7%	18.8%	31.1%	
	Very good	37.1%	37.3%	36.9%	38.6%	31.7%	39.6%	39.9%	34.6%	47.5%	43.6%	36.7%	27.9%	33.9%	29.8%	26.0%	35.2%	41.8%	40.3%	
	Good	29.5%	30.4%	28.8%	28.2%	33.8%	36.0%	29.6%	29.4%	27.9%	25.6%	28.1%	37.5%	29.3%	30.8%	31.5%	35.1%	28.3%	23.9%	
	Fair	10.4%	10.0%	10.7%	9.1%	15.0%	4.7%	8.6%	11.8%	4.9%	7.2%	10.3%	11.3%	12.2%	18.1%	22.2%	12.7%	8.5%	3.9%	
	Poor	3.3%	2.6%	3.8%	3.2%	3.5%	1.1%	3.0%	3.5%	0.6%	1.1%	2.7%	5.2%	8.2%	4.4%	9.0%	3.4%	2.6%	0.9%	
	Don't know	0.2%	0.3%	0.1%	0.2%	0.2%	0.0%	0.0%	0.4%	0.0%	0.0%	0.2%	0.0%	0.8%	0.6%	1.5%	0.0%	0.0%	0.0%	
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?	0	N=2802	N=1293	N=1509	N=2133	N=617	N=52	N=1296	N=1505	N=388	N=642	N=614	N=448	N=295	N=416	N=394	N=875	N=697	N=836	
	1-2	68.7%	71.4%	66.4%	69.3%	66.6%	70.9%	69.8%	67.8%	66.8%	73.4%	68.9%	66.8%	67.9%	65.8%	58.9%	68.6%	66.3%	75.5%	
	3-8	9.1%	8.6%	9.5%	8.3%	11.3%	15.5%	9.2%	9.9%	11.7%	12.1%	10.9%	8.9%	4.8%	2.5%	6.5%	8.1%	10.6%	10.1%	
	8-29	8.4%	8.0%	8.9%	8.8%	7.8%	1.5%	8.0%	8.8%	14.6%	9.8%	7.6%	8.2%	3.9%	5.4%	8.1%	9.3%	9.4%	6.9%	
	30	5.7%	4.8%	6.6%	5.5%	6.4%	8.8%	5.2%	6.2%	5.0%	3.0%	6.5%	6.7%	8.4%	6.8%	11.2%	5.8%	6.5%	2.5%	
	Don't know/Refused	30	6.5%	6.0%	7.0%	6.7%	6.4%	2.3%	6.0%	7.0%	1.2%	1.1%	4.8%	7.9%	14.1%	15.5%	13.2%	6.9%	5.1%	4.1%
		1.5%	1.4%	1.7%	1.5%	1.6%	1.1%	1.8%	1.2%	0.8%	0.6%	1.4%	1.6%	1.0%	4.2%	2.1%	1.4%	2.1%	1.0%	
Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days in the past 30 days was your mental health not good?	0	N=2802	N=1293	N=1509	N=2133	N=617	N=52	N=1296	N=1505	N=388	N=642	N=614	N=448	N=295	N=416	N=394	N=875	N=697	N=836	
	1-2	69.3%	74.4%	64.9%	70.0%	67.3%	64.4%	73.3%	65.8%	57.0%	65.0%	62.6%	70.8%	80.1%	88.0%	66.0%	66.9%	67.4%	75.0%	
	3-8	7.0%	5.6%	8.2%	6.9%	7.0%	11.5%	7.0%	6.9%	10.5%	9.6%	8.4%	7.0%	2.1%	0.9%	3.0%	6.2%	8.6%	8.2%	
	8-29	9.4%	8.0%	10.5%	8.9%	11.0%	8.5%	8.4%	10.2%	13.3%	11.8%	13.7%	7.4%	3.2%	1.8%	9.2%	9.5%	10.2%	8.5%	
	30	7.5%	5.7%	9.1%	7.3%	8.4%	8.1%	6.1%	8.8%	11.9%	10.3%	7.1%	6.6%	5.5%	2.4%	9.8%	9.3%	7.6%	4.6%	
	Don't know/Refused	30	5.3%	4.8%	5.7%	5.4%	5.0%	5.0%	6.2%	6.2%	5.9%	2.4%	6.5%	7.2%	6.8%	4.3%	9.2%	6.3%	5.0%	2.6%
		1.6%	1.6%	1.6%	1.6%	1.5%	2.5%	1.1%	2.0%	1.4%	0.9%	1.8%	1.0%	2.4%	2.6%	2.8%	1.8%	1.2%	1.1%	
During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	0	N=2802	N=1293	N=1509	N=2133	N=617	N=52	N=1296	N=1505	N=388	N=642	N=614	N=448	N=295	N=416	N=394	N=875	N=697	N=836	
	1-2	26.0%	23.8%	28.0%	25.7%	27.0%	27.6%	24.8%	27.1%	34.0%	28.9%	27.2%	25.3%	14.7%	21.4%	24.7%	27.1%	28.5%	23.5%	
	3-8	5.3%	4.6%	5.9%	5.3%	5.1%	9.6%	4.9%	5.7%	8.1%	7.0%	6.5%	4.7%	2.8%	0.8%	4.3%	4.6%	5.4%	6.6%	
	8-29	4.7%	4.5%	4.8%	4.5%	5.4%	2.4%	4.2%	5.1%	8.1%	5.1%	4.3%	4.5%	3.1%	2.5%	5.4%	5.3%	5.9%	2.6%	
	30	4.0%	2.9%	5.0%	3.8%	4.7%	5.1%	3.4%	4.6%	3.5%	3.1%	4.4%	4.9%	6.4%	2.8%	6.0%	5.1%	4.2%	1.8%	
	Don't know/Refused	30	2.5%	2.7%	2.4%	2.6%	2.6%	1.4%	1.9%	3.1%	0.8%	0.5%	2.8%	3.8%	5.5%	3.3%	6.1%	2.5%	2.4%	1.1%
		57.4%	61.5%	54.0%	58.1%	55.3%	53.9%	60.8%	54.5%	45.6%	55.3%	54.8%	56.8%	67.5%	69.2%	53.5%	55.5%	53.7%	64.4%	

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996.

Question	Response	Planning Districts															
		Joelton	Belshire/ Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts ville	East Nashville/ Inglewood	Bellevue	Belle Meade/ West Meade	North Nashville	Downtown	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tuculcum/ Creeve Hall	Priest Lake/ Antioch	Donelson/ Hernitage		
1996 In general, would you say your health is:		N*=176	N*=200	N*=180	N*=215	N*=190	N*=208	N*=219	N*=174	N*=179	N*=199	N*=206	N*=213	N*=218	N*=216		
	Excellent	15.4%	13.3%	11.7%	18.4%	20.5%	26.2%	23.6%	17.2%	16.6%	22.2%	24.0%	20.6%	22.4%	20.0%		
	Very good	39.1%	34.1%	36.4%	37.2%	31.5%	42.9%	41.1%	31.5%	25.2%	37.4%	33.8%	39.9%	37.9%	47.1%		
	Good	28.7%	32.9%	34.1%	26.1%	32.0%	22.3%	26.5%	30.5%	37.6%	30.6%	31.9%	29.7%	30.3%	22.8%		
	Fair	12.0%	15.9%	11.8%	12.1%	11.2%	6.4%	6.5%	14.5%	17.6%	7.8%	9.0%	8.4%	7.0%	7.6%		
	Poor	4.7%	3.9%	6.0%	6.0%	3.6%	2.0%	2.4%	5.2%	3.0%	2.0%	1.2%	1.5%	2.3%	2.6%		
	Don't know	0.0%	0.0%	0.0%	0.3%	1.1%	0.3%	0.0%	1.1%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%		
Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?		N*=176	N*=200	N*=180	N*=215	N*=190	N*=208	N*=219	N*=174	N*=179	N*=199	N*=206	N*=213	N*=218	N*=216		
	0	64.9%	63.8%	65.3%	64.6%	69.9%	69.4%	78.8%	61.9%	70.3%	73.7%	68.0%	69.9%	66.3%	73.2%		
	1-2	12.0%	7.9%	9.9%	7.7%	10.4%	9.9%	6.6%	9.5%	7.8%	5.2%	9.3%	11.4%	10.5%	9.2%		
	3-8	5.4%	12.5%	10.0%	10.6%	7.0%	8.7%	6.2%	10.7%	4.8%	7.8%	8.8%	10.4%	7.3%	7.5%		
	8-29	7.2%	6.2%	3.8%	8.7%	5.1%	4.0%	3.8%	6.4%	5.2%	4.4%	7.5%	3.0%	10.7%	4.2%		
	30	9.8%	7.0%	9.8%	7.6%	5.6%	5.8%	4.1%	10.2%	9.7%	6.7%	3.9%	2.5%	4.7%	5.9%		
	Don't know/Refused	0.8%	2.7%	1.2%	0.8%	2.0%	2.2%	0.5%	1.2%	2.2%	2.2%	2.6%	2.8%	0.3%	0.0%		
Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days in the past 30 days was your mental health not good?		N*=176	N*=200	N*=180	N*=215	N*=190	N*=208	N*=219	N*=174	N*=179	N*=199	N*=206	N*=213	N*=218	N*=216		
	0	75.3%	67.8%	68.5%	70.5%	63.7%	65.4%	73.4%	60.2%	70.2%	73.9%	70.0%	67.2%	73.3%	69.7%		
	1-2	4.9%	4.4%	4.6%	9.9%	11.0%	10.7%	6.2%	8.2%	6.3%	5.4%	4.7%	8.7%	2.9%	9.4%		
	3-8	7.7%	9.6%	11.2%	5.1%	13.3%	14.0%	8.9%	8.9%	6.2%	8.8%	8.9%	11.1%	8.8%	8.3%		
	8-29	6.3%	8.0%	7.3%	9.0%	6.0%	5.9%	5.7%	12.2%	6.8%	7.0%	10.7%	7.6%	8.2%	5.5%		
	30	3.7%	7.0%	7.7%	3.3%	4.7%	2.3%	4.4%	6.6%	9.3%	4.6%	5.2%	4.5%	6.4%	5.1%		
	Don't know/Refused	2.1%	3.2%	0.7%	2.1%	1.3%	1.8%	1.4%	4.0%	1.4%	0.4%	0.5%	1.0%	0.4%	2.1%		
During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?		N*=176	N*=200	N*=180	N*=215	N*=190	N*=208	N*=219	N*=174	N*=179	N*=199	N*=206	N*=213	N*=218	N*=216		
	0	25.5%	27.6%	26.6%	27.2%	26.9%	27.2%	18.3%	24.9%	26.1%	24.7%	27.1%	30.6%	27.2%	24.9%		
	1-2	6.0%	4.2%	3.6%	3.7%	8.4%	7.4%	3.4%	4.6%	3.1%	5.8%	4.9%	7.6%	4.8%	6.9%		
	3-8	3.4%	2.6%	5.7%	3.4%	5.8%	5.6%	5.2%	7.8%	5.1%	3.4%	6.8%	4.5%	2.8%	3.7%		
	8-29	3.0%	3.5%	2.7%	7.3%	4.6%	3.5%	4.2%	4.4%	4.6%	3.2%	4.7%	1.4%	5.8%	3.2%		
	30	3.8%	0.8%	5.6%	3.9%	2.4%	2.1%	0.9%	4.9%	3.5%	1.5%	1.9%	0.0%	2.4%	2.8%		
	Don't know/Refused	58.3%	61.4%	55.7%	54.6%	51.9%	54.3%	68.0%	53.3%	57.6%	61.4%	54.7%	55.9%	57.1%	58.5%		

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1996.

Data Table 39. Responses to BRFSS Questions Regarding Health Status and Activity Limitation Days, Nashville, TN, 1998

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998 Would you say that your health is:		N=3230	N=1488	N=1742	N=2447	N=723	N=61	N=1499	N=1724	N=438	N=702	N=726	N=549	N=337	N=477	N=369	N=983	N=843	N=1055
	Excellent	24.4%	27.5%	21.7%	25.8%	18.6%	25.5%	27.6%	21.7%	28.4%	28.6%	28.8%	25.8%	21.3%	17.5%	12.7%	15.9%	25.5%	36.0%
	Very Good	31.8%	30.1%	33.3%	33.3%	27.0%	28.3%	33.1%	30.8%	32.4%	38.2%	31.1%	32.6%	24.0%	27.7%	22.3%	30.2%	34.0%	35.1%
	Good	30.6%	30.7%	30.5%	28.9%	33.9%	33.6%	29.3%	31.6%	31.8%	28.1%	29.9%	32.0%	35.0%	32.3%	35.3%	38.1%	28.7%	23.2%
	Fair	9.6%	8.2%	10.8%	8.1%	14.5%	9.3%	8.0%	10.9%	6.3%	5.6%	6.6%	9.6%	16.2%	18.3%	19.7%	12.0%	8.5%	4.5%
	Poor	3.5%	3.2%	3.8%	3.6%	3.1%	3.3%	2.1%	4.8%	1.2%	1.4%	2.7%	4.3%	7.3%	6.4%	9.9%	3.9%	3.2%	1.1%
	Don't Know	0.1%	0.3%	0.0%	0.2%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%	0.0%	0.3%	0.0%	0.4%	0.0%	0.0%	0.5%	0.1%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Now thinking about your physical health, which includes physical fitness and injury, for how many days during the past 30 days was your physical health not good?		N=3230	N=1488	N=1742	N=2447	N=723	N=61	N=1499	N=1724	N=438	N=702	N=726	N=549	N=337	N=477	N=369	N=983	N=843	N=1055
	0	67.7%	71.9%	64.2%	68.8%	64.3%	64.5%	70.8%	65.1%	59.0%	67.4%	72.1%	68.8%	66.0%	69.6%	59.3%	68.1%	67.6%	70.5%
	1-2	12.2%	10.5%	13.7%	12.0%	12.8%	15.4%	11.8%	12.5%	20.2%	16.1%	12.2%	11.3%	5.9%	4.6%	9.2%	9.1%	13.5%	15.2%
	3-8	9.4%	8.6%	10.2%	8.5%	12.2%	15.1%	8.7%	10.1%	14.3%	10.0%	6.4%	8.7%	10.4%	8.7%	10.1%	10.7%	9.3%	8.1%
	8-29	5.3%	4.8%	5.5%	5.3%	5.0%	2.8%	4.0%	6.3%	3.8%	4.1%	4.9%	5.7%	7.8%	6.1%	10.5%	5.2%	4.7%	3.7%
	30	4.1%	3.4%	4.7%	4.2%	4.2%	1.2%	3.7%	4.5%	0.9%	2.2%	3.4%	5.0%	7.9%	7.4%	8.4%	5.5%	3.5%	1.8%
	Don't Know/Refused	1.3%	0.9%	1.7%	1.3%	1.5%	1.0%	1.0%	1.6%	1.8%	0.3%	0.9%	0.4%	2.0%	3.6%	2.5%	1.5%	1.4%	0.8%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days in the past 30 days was your mental health not good?		N=3230	N=1488	N=1742	N=2447	N=723	N=61	N=1499	N=1724	N=438	N=702	N=726	N=549	N=337	N=477	N=369	N=983	N=843	N=1055
	0	65.3%	70.8%	60.6%	65.6%	64.2%	64.6%	69.7%	61.4%	50.0%	56.6%	63.4%	68.3%	77.0%	83.3%	63.4%	64.2%	66.1%	66.3%
	1-2	10.5%	9.3%	11.0%	10.8%	9.5%	13.4%	10.5%	10.6%	16.0%	13.9%	11.6%	8.9%	7.1%	3.3%	5.5%	8.7%	10.9%	13.9%
	3-8	10.6%	8.8%	12.1%	10.6%	11.1%	3.5%	9.7%	11.3%	17.0%	15.0%	10.4%	8.6%	5.8%	3.8%	11.3%	11.0%	8.8%	11.4%
	8-29	7.7%	6.6%	8.7%	7.1%	9.7%	10.6%	5.1%	10.0%	12.7%	8.7%	8.6%	7.7%	4.4%	2.9%	10.7%	8.2%	9.6%	4.7%
	30	4.7%	3.7%	5.6%	4.6%	5.2%	3.9%	4.1%	5.3%	3.4%	4.6%	5.2%	5.8%	4.6%	4.2%	7.7%	6.4%	3.8%	2.8%
	Don't Know/Refused	1.2%	0.8%	1.5%	1.4%	0.3%	3.9%	0.9%	1.4%	1.0%	1.2%	0.8%	0.8%	1.2%	2.5%	1.7%	1.6%	0.9%	0.9%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?		N=3230	N=1488	N=1742	N=2447	N=723	N=61	N=1499	N=1724	N=438	N=702	N=726	N=549	N=337	N=477	N=369	N=983	N=843	N=1055
	0	82.2%	84.3%	80.4%	81.8%	83.5%	81.6%	86.1%	78.9%	78.5%	81.0%	84.6%	80.8%	81.1%	86.1%	77.1%	81.0%	81.8%	85.5%
	1-2	6.0%	5.0%	6.7%	6.4%	4.4%	4.6%	5.3%	6.4%	10.4%	7.5%	5.1%	6.1%	3.8%	2.3%	4.1%	5.6%	6.8%	6.3%
	3-8	4.6%	3.8%	5.3%	4.5%	4.9%	4.0%	3.6%	5.5%	6.1%	5.6%	3.6%	4.7%	5.2%	2.8%	5.9%	5.2%	4.2%	4.0%
	8-29	3.9%	3.5%	4.2%	3.8%	4.0%	3.1%	2.6%	5.0%	1.6%	4.0%	4.3%	4.1%	5.1%	3.9%	5.8%	4.2%	4.5%	2.3%
	30	2.6%	2.5%	2.7%	2.7%	2.1%	2.8%	2.1%	3.0%	1.6%	1.6%	2.2%	3.6%	4.1%	3.3%	5.4%	3.5%	1.5%	1.7%
	Don't Know/Refused	0.8%	0.9%	0.8%	0.7%	1.1%	3.9%	0.4%	1.2%	2.0%	0.3%	0.2%	0.8%	0.8%	1.6%	1.8%	0.7%	1.2%	0.3%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Numbers have been adjusted to match the gender-race-age distribution of Davidson County, TN for 1998.

		Planning Districts										Planning Districts, Continued							
Question	Response	Joelton	Belshire/ Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts-ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/ West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage		
1998		N=182	N=206	N=199	N=199	N=193	N=208	N=202	N=205	N=179	N=187	N=206	N=194	N=206	N=216	N=222	N=227		
Would you say that your health is:		19.9%	22.7%	21.2%	17.3%	13.2%	30.8%	31.0%	32.2%	16.1%	18.1%	31.8%	32.3%	27.7%	21.9%	26.8%	24.8%		
	Excellent	19.9%	22.7%	21.2%	17.3%	13.2%	30.8%	31.0%	32.2%	16.1%	18.1%	31.8%	32.3%	27.7%	21.9%	26.8%	24.8%		
	Very Good	28.1%	29.9%	35.2%	40.1%	32.3%	40.2%	32.8%	35.0%	28.5%	21.8%	30.2%	28.5%	27.5%	33.7%	26.5%	37.0%		
	Good	35.8%	36.0%	29.0%	28.5%	36.7%	21.7%	25.2%	23.7%	29.0%	36.9%	28.8%	28.2%	29.9%	35.4%	35.6%	29.1%		
	Fair	11.7%	8.8%	11.3%	10.0%	14.7%	5.9%	7.6%	6.5%	17.8%	17.6%	7.4%	7.5%	10.6%	5.8%	6.8%	6.4%		
	Poor	4.4%	2.7%	3.5%	4.2%	3.1%	1.3%	3.0%	2.1%	8.7%	4.9%	1.7%	3.5%	4.3%	2.6%	4.3%	2.8%		
	Don't Know	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.5%	0.0%	0.8%	0.0%	0.0%	0.0%	0.6%	0.6%	0.0%		
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?		N=182	N=206	N=199	N=199	N=193	N=208	N=202	N=205	N=179	N=187	N=206	N=194	N=206	N=216	N=222	N=227		
	0	62.9%	66.5%	73.2%	66.5%	65.3%	74.4%	76.9%	69.0%	64.0%	54.8%	69.0%	69.0%	64.4%	63.2%	67.5%	74.6%		
	1-2	14.9%	13.7%	4.1%	12.7%	8.9%	11.6%	8.4%	16.3%	11.4%	13.5%	12.5%	14.1%	13.7%	15.9%	12.4%	11.0%		
	3-8	11.0%	8.5%	9.6%	9.0%	10.2%	6.7%	8.9%	8.4%	11.7%	13.5%	11.4%	5.8%	8.6%	9.8%	11.0%	7.3%		
	8-29	3.9%	3.5%	5.6%	8.3%	7.6%	4.5%	2.5%	3.9%	5.6%	9.5%	1.5%	7.2%	4.6%	5.2%	5.1%	5.2%		
	30	6.0%	5.7%	4.4%	3.1%	5.0%	2.1%	2.2%	2.4%	5.6%	7.8%	3.4%	3.0%	7.3%	4.4%	3.5%	1.2%		
	Don't Know/Refused	1.4%	2.1%	3.2%	0.4%	3.0%	0.8%	1.1%	0.0%	1.6%	0.8%	2.3%	0.9%	1.5%	1.5%	0.4%	0.7%		
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days in the past 30 days was your mental health not good?		N=182	N=206	N=199	N=199	N=193	N=208	N=202	N=205	N=179	N=187	N=206	N=194	N=206	N=216	N=222	N=227		
	0	71.6%	63.6%	71.6%	62.6%	64.3%	67.2%	73.7%	64.9%	63.3%	58.6%	71.3%	68.0%	58.7%	54.7%	64.2%	66.6%		
	1-2	9.9%	9.5%	7.9%	5.2%	7.9%	12.5%	10.5%	11.2%	9.3%	10.0%	12.6%	14.6%	14.8%	12.4%	11.4%	8.5%		
	3-8	11.5%	11.9%	9.0%	13.3%	10.7%	9.8%	6.6%	10.1%	8.3%	10.8%	5.7%	9.7%	9.4%	15.3%	10.6%	15.5%		
	8-29	3.6%	7.9%	7.0%	11.1%	10.9%	4.9%	3.9%	8.6%	13.7%	12.0%	5.8%	3.6%	8.1%	8.1%	10.0%	5.4%		
	30	2.7%	5.0%	3.4%	7.1%	5.4%	4.4%	3.3%	5.2%	4.4%	7.7%	3.1%	2.1%	8.0%	7.1%	3.3%	3.2%		
	Don't Know/Refused	0.7%	2.1%	1.1%	0.7%	0.7%	1.2%	2.0%	0.0%	1.1%	1.0%	1.5%	2.1%	0.9%	2.5%	0.6%	1.1%		
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?		N=182	N=206	N=199	N=199	N=193	N=208	N=202	N=205	N=179	N=187	N=206	N=194	N=206	N=216	N=222	N=227		
	0	82.4%	85.2%	81.2%	79.9%	76.6%	87.8%	87.7%	81.4%	82.6%	75.7%	82.6%	83.1%	78.5%	77.1%	84.4%	87.6%		
	1-2	5.7%	4.7%	2.1%	4.8%	7.2%	4.5%	5.9%	7.8%	4.1%	9.2%	7.4%	8.8%	7.3%	6.0%	5.4%	4.6%		
	3-8	4.1%	3.0%	7.2%	7.6%	4.9%	3.9%	2.7%	2.4%	5.4%	4.1%	4.0%	3.3%	5.2%	8.2%	5.3%	2.5%		
	8-29	3.7%	2.8%	4.8%	4.0%	6.4%	2.9%	3.2%	5.4%	4.5%	6.1%	2.1%	2.3%	4.0%	2.8%	3.7%	3.4%		
	30	2.7%	3.1%	2.1%	2.8%	5.0%	0.9%	0.5%	2.5%	2.7%	4.3%	2.7%	2.8%	3.8%	3.9%	0.9%	1.5%		
	Don't Know/Refused	1.4%	1.1%	2.6%	1.0%	0.0%	0.0%	0.0%	0.7%	0.7%	0.6%	1.3%	0.0%	1.1%	2.0%	0.3%	0.3%		
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			

Data Table 40. Number of Teen and Adolescent Births by Race and Age, Nashville, TN, 1990-2000

Year	All Races				White				Black				Other			
	10-19	10-17	10-14	15-19	10-19	10-17	10-14	15-19	10-19	10-17	10-14	15-19	10-19	10-17	10-14	15-19
1990	1308	491	33	1275	672	210	5	667	619	272	28	591	17	9	0	17
1991	1337	546	32	1305	684	240	8	676	632	300	24	608	21	6	0	21
1992	1245	536	42	1203	619	230	10	609	607	300	30	577	19	6	2	17
1993	1281	554	35	1246	603	220	7	596	667	332	28	639	11	2	0	11
1994	1253	520	44	1209	632	231	9	623	609	285	35	574	12	4	0	12
1995	1187	495	38	1149	563	191	6	557	609	297	32	577	15	7	0	15
1996	1275	528	49	1226	608	218	12	596	634	292	35	599	33	18	2	31
1997	1181	479	19	1162	568	199	4	564	580	263	15	565	33	17	0	33
1998	1249	487	36	1213	633	223	13	620	595	256	23	572	21	8	0	21
1999	1175	428	31	1144	601	196	11	590	547	221	20	527	27	11	0	27
2000	1147	434	24	1123	566	184	7	559	552	238	17	535	29	12	0	29

Data Table 41. Teen and Adolescent Birth Rates* by Race and Age, Nashville, TN, 1990-2000

Year	All Races				White				Black				Other				Disparity ¹		
	10-19	10-17	10-14	15-19	10-19	10-17	10-14	15-19	10-19	10-17	10-14	15-19	10-19	10-17	10-14	15-19	10-19	10-17	15-19
1990	40.9	20	2.2	74	32.5	13.3	^	59.8	59.1	33.3	5.8	104.8	21.8	^	^	38.6	81.8	150.4	75.3
1991	41.7	22	2.1	75.9	33	15.1	^	61	59.6	36.3	4.9	107.3	26.6	^	^	47.5	80.6	140.4	75.9
1992	38.4	21.3	2.8	69.7	29.7	14.3	1	54.9	56.3	35.5	5.9	100.7	23.7	^	^	37.9	89.6	148.3	83.4
1993	39	21.7	2.3	71.8	28.7	13.5	^	53.7	60.7	38.5	5.4	110.2	13.5	^	^	24.3	111.5	185.2	105.2
1994	37.7	20.1	2.8	69.3	29.8	14.1	^	56	54.4	32.4	6.6	97.8	14.4	^	^	26.2	82.6	129.8	74.6
1995	35.4	18.9	2.4	65.7	26.4	11.5	^	50.1	53.6	33.2	5.9	97.4	17.8	^	^	32.5	103.0	188.7	94.4
1996	37.7	20	3	70.1	28.4	13.1	1.2	53.9	55	32.2	6.3	100.5	38.6	27.1	^	66.7	93.7	145.8	86.5
1997	35	18.1	1.2	67	26.7	11.9	^	51.6	50.1	28.8	2.7	94.9	38.4	25.4	^	71	87.6	142.0	83.9
1998	30.5	18.3	2.2	70.2	24.6	13.4	1.2	57.2	42.2	27.7	4	95.9	19.8	^	^	45.3	71.5	106.7	67.7
1999	35	16.1	1.9	67.1	28.5	11.8	1.1	55.3	46.9	23.9	3.5	88.9	31.3	16.3	^	58.4	64.6	102.5	60.8
2000	32.7	16.9	1.5	59.2	28.7	12.8	^	51.9	43.7	25.6	2.8	80.2	10.5	6	^	19.2	52.3	100.0	54.5

*Births are per 1,000 women in age group

^Rates are not calculated when the number of births is less than 10.

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((black rate - white rate) / white rate) X 100.

Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase. The disparity for the 10-14 age group was not calculated due to small numbers.

Data Table 42. Number of Births with Age-specific Birth Rates per 1,000 Females Aged 10-14, by Race, for Selected Counties and Tennessee, 2000

County	All Races		White		Black		Disparity ¹
	Number	Rate	Number	Rate	Number	Rate	
Nashville	24	1.5	7	0.8	17	2.8	250.0
Hamilton	18	1.8	4	0.6	14	5	733.3
Knox	13	1.1	8	0.8	5	3.9	387.5
Shelby	83	2.4	10	0.8	73	3.6	350.0
Tennessee	224	1.2	91	0.6	132	3.2	433.3

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks.

It is calculated as follows: ((black rate - white rate)/ white rate) X 100.

Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 43. Number of Births with Age-specific Birth Rates per 1,000 Females Aged 10-17, by Race, for Selected Counties and Tennessee, 2000

County	All Races		White		Black		Disparity ¹
	Number	Rate	Number	Rate	Number	Rate	
Nashville	434	16.9	184	12.8	238	25.6	100.0
Hamilton	221	13.7	100	8.9	120	28.3	218.0
Knox	176	9.5	124	7.9	51	25.4	221.5
Shelby	935	17.2	192	9.2	737	23.4	154.3
Tennessee	3,984	13.1	2,443	10.6	1,499	23.4	120.8

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks.

It is calculated as follows: ((black rate - white rate)/ white rate) X 100.

Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 44. Number of Births with Age-specific Birth Rates per 1,000 Females Aged 15-19, by Race, for Selected Counties and Tennessee, 2000

County	All Races		White		Black		Disparity ¹
	Number	Rate	Number	Rate	Number	Rate	
Nashville	1,123	59.2	559	51.9	535	80.2	54.5
Hamilton	598	58.2	328	45	264	104.7	132.7
Knox	523	38.8	393	34.3	127	84.1	145.2
Shelby	2,317	72	486	38.5	1,811	99.2	157.7
Tennessee	11,406	59.2	7,674	52.7	3,618	91.3	73.2

Total may include events with race other than white or black

¹The disparity is the percentage difference between whites and blacks.

It is calculated as follows: ((black rate - white rate)/ white rate) X 100.

Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 45. Number of Births with Age-specific Birth Rates per 1,000 Females Aged 10-19, by Race, for Selected Counties and Tennessee, 2000

County	All Races		White		Black		Disparity ¹
	Number	Rate	Number	Rate	Number	Rate	
Nashville	1,147	32.7	566	28.7	552	43.7	52.3
Hamilton	616	30	332	23.2	278	52.3	125.4
Knox	536	21.3	401	18.8	132	47.5	152.7
Shelby	2,400	35.9	496	19.3	1,884	48.7	152.3
Tennessee	11,630	30.2	7,765	26.8	3,750	46.3	72.8

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks.

It is calculated as follows: ((black rate - white rate)/ white rate) X 100.

Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 46. Number of Live Births and Birthrates* by Race for Females Age 15-44, Nashville, TN, 1990-2000

Year	All Races		White		Black		Other	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
1990	8,706	65.5	5,962	61.6	2,592	77.8	152	54.5
1991	8,645	65.4	5,821	60.8	2,686	80.0	138	49.2
1992	8,439	63.8	5,714	59.8	2,560	75.3	165	57.9
1993	8,334	62.8	5,503	57.8	2,650	76.8	181	62.7
1994	8,171	61.4	5,518	58.0	2,429	69.4	224	76.4
1995	8,218	61.8	5,438	57.5	2,505	70.7	275	92.8
1996	8,245	62.2	5,501	58.6	2,399	67.1	345	115.5
1997	8,332	63.5	5,504	59.5	2,480	69.2	348	116.3
1998	8,454	64.9	5,576	61.1	2,525	70.3	352	117.2
1999	8,484	66.2	5,503	61.5	2,580	72.1	399	133.4
2000^	8,946	64.1	5,711	63.5	2,748	69.1	487	49.3

*Birthrates are per 1,000 women in age group

^The difference in birthrates from 1999 to 2000 for some groups are primarily due to the significant differences between the year 2000 census population used to calculate the 2000 birthrates and the estimated population used to calculate the 1999 birthrates.

Data Table 48. Number and Percent of All Live Births to Unmarried Women, Nashville, TN, 1990-2000

Year	All Races		White		Black		Other		Disparity ¹
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	
1990	3,094	35.5	1,221	20.5	1,848	71.3	25	16.4	247.8
1991	3,278	37.9	1,285	22.1	1,970	73.3	23	16.7	231.7
1992	3,176	37.6	1,294	22.6	1,839	71.8	43	26.1	217.7
1993	3,383	40.6	1,348	24.5	1,995	75.3	40	22.1	207.3
1994	3,216	39.4	1,402	25.4	1,773	73.0	41	18.3	187.4
1995	3,159	38.4	1,293	23.8	1,798	71.8	68	24.7	201.7
1996	3,219	39.0	1,363	24.8	1,758	73.3	98	28.4	195.6
1997	3,249	38.9	1,354	24.6	1,805	72.3	90	25.8	193.9
1998	3,453	40.6	1,492	26.7	1,868	73.2	93	26.4	174.2
1999	3,410	40.0	1,451	26.3	1,843	70.9	114	28.5	169.6
2000	3,541	39.4	1,502	26.2	1,907	68.9	132	27.1	163.0

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows:

$(\% \text{ black} - \% \text{ white}) / \% \text{ white} \times 100$. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 50. Percentage of Women with Live Births Who Entered Prenatal Care During the First Trimester by Race and Age, Nashville, TN, 1990-2000

Year	All Races		White		Black		Other		Disparity ¹	
	All	10-19	All	10-19	All	10-19	All	10-19	All	10-19
1990	82.9	64.4	87.5	67.3	72.5	62	80.9	^	-17.1	-7.9
1991	82.8	65.1	87.8	70.6	72.2	59.2	76.1	66.7	-17.8	-16.1
1992	84.6	70.8	89.6	79.2	73.9	63.6	77.6	^	-17.5	-19.7
1993	86.7	73.8	91	77.9	77.9	70.3	86.2	^	-14.4	-9.8
1994	86.8	74.9	90.2	79.1	79.3	70.9	83.9	^	-12.1	-10.4
1995	88.2	75.9	90.8	78	83.1	74.1	83.6	73.3	-8.5	-5.0
1996	88.6	78.8	91.5	78.5	83.5	79.7	82.3	69.7	-8.7	1.5
1997	88.8	78.4	90.6	78.3	85.2	78.6	85.9	75.8	-6.0	0.4
1998	88.4	79.3	90.5	79.9	84.6	79.5	82.1	57.1	-6.5	-0.5
1999	88	81.8	90	81.5	86.7	82.4	77.8	74.1	-3.7	1.1
2000	84.4	74.4	86.1	74	82.1	75.7	76.6	58.6	-4.6	2.3

^Percentage not calculated when the number of births is less than 10

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows:

$(\% \text{ black} - \% \text{ white}) / \% \text{ white} \times 100$. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 47. Number of Live Births with General Fertility Rates by Race, for Selected Counties and Tennessee, 2000

County	All Races		White		Black	
	Number	Rate	Number	Rate	Number	Rate
Nashville	8,981	64.1	5,727	63.5	2,767	69.1
Hamilton	4,028	60.5	2,859	58.3	1,078	72.3
Knox	4,796	54.6	4,178	54.8	494	58.8
Shelby	14,742	70.5	5,779	64.0	8,582	78.0
Tennessee	79,539	63.6	60,928	62.6	16,878	72.7

Total may include events with race other than white or black.

Data Table 49. Number and Percent of Births to Unmarried Women, by Race of Mother, for Selected Counties and Tennessee, 2000

County	All Races		White		Black		Disparity ¹
	Number	Percent	Number	Percent	Number	Percent	
Nashville	3,541	39.4	1,502	26.2	1,907	68.9	163.0
Hamilton	1,564	38.8	742	26.0	806	74.8	187.7
Knox	1,268	26.4	888	21.3	366	74.1	247.9
Shelby	7,579	51.4	1,140	19.7	6,378	74.3	277.2
Tennessee	27,490	34.6	14,910	24.5	12,207	72.3	195.1

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks. It is calculated

as follows: $(\% \text{ black} - \% \text{ white}) / \% \text{ white} \times 100$. Negative numbers

indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 51. Percentage of Women with Live Births Who Started Prenatal Care During the First Trimester by Race and Age, for Selected Counties, Tennessee, and the U.S., 2000

County	All Races		White		Black		Disparity ¹	
	All	10-19	All	10-19	All	10-19	All	10-19
Nashville	84.4	74.4	86.1	74	82.1	75.7	-4.6	2.3
Hamilton	83.7	83.7	87.8	77.1	73.5	67.6	-16.3	-12.3
Knox	86.1	86.1	87.9	72.6	72.3	58.3	-17.7	-19.7
Shelby	74.7	74.7	84.8	63.1	67.8	56.1	-20.0	-11.1
Tennessee	81.4	81.4	84.6	73	70.5	61	-16.7	-16.4
U.S.	83.2	^	85	^	74.3	^	-12.6	^

^Data not available

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks. It is calculated

as follows: $(\% \text{ black} - \% \text{ white}) / \% \text{ white} \times 100$. Negative numbers

indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 52. Percentage of Women with Live Births Who Received No Prenatal Care During the Third Trimester by Race and Age, Nashville, TN, 1990-2000

	All Races		White		Black		Other		Disparity ¹	
Year	All	10-19	All	10-19	All	10-19	All	10-19	All	10-19
1990	3.5	7.3	2.4	6.4	5.8	7.9	^	^	141.7	23.4
1991	3.3	6.6	2	6	6.1	7.4	^	^	205.0	23.3
1992	3.2	6.3	2.2	5.5	5.5	7.1	^	^	150.0	29.1
1993	2.4	3.9	1.4	2.7	4.3	5.1	^	^	207.1	88.9
1994	3.1	5.9	2.2	5.2	5.2	6.4	^	^	136.4	23.1
1995	2.8	6.5	1.8	5.3	5	7.7	^	^	177.8	45.3
1996	2.9	4.9	1.9	3.8	5.2	5.5	4.9	^	173.7	44.7
1997	3	4.9	2.1	4.8	4.9	5.2	3.2	^	133.3	8.3
1998	3.2	3.4	2.2	4.4	5.1	1.8	4.5	^	131.8	-59.1
1999	3.9	5.6	2.7	4.2	6.2	6.9	5	^	129.6	64.3
2000	3.9	6.7	3	4.9	5.5	8	4.7	^	83.3	63.3

[^]Percentage not calculated because there were fewer than 10 births in the group.

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows:

$((\% \text{ black} - \% \text{ white}) / \% \text{ white}) \times 100$. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 53. Percentage of Females with Live Births Who Received Late or No Prenatal Care by Race and Age, for Selected Counties, Tennessee, and the U.S., 2000

	All Races		White		Black		Disparity ¹	
County	All	10-19	All	10-19	All	10-19	All	10-19
Nashville	3.9	6.7	3	4.9	5.5	8	83.3	63.27
Hamilton	3.3	5.7	2.4	3.3	5.9	8.6	145.8	160.61
Knox	2.9	6.5	2.2	5.7	8.7	9.1	295.5	59.65
Shelby	8	12.2	5.2	12.5	10	12	92.3	-4.00
Tennessee	4.1	6.6	2.9	4.8	8	10.1	175.9	110.42
U.S.	3.9	^	2.9	^	7.2	^	148.3	^

[^]Data not available

Total may include events other than white or black.

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows:

$((\% \text{ black} - \% \text{ white}) / \% \text{ white}) \times 100$. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 54. Infant Mortality Rates* by Race², and Fetal Mortality Rates³, Nashville, TN, 1990-2000

	All Races				White				Black				Disparity ⁴			
Year	Fetal	Infant ¹	Neonatal ¹	Postneonatal ¹	Fetal	Infant	Neonatal	Postneonatal	Fetal	Infant	Neonatal	Postneonatal	Fetal	Infant	Neonatal	Postneonatal
1990	5.5	9.5	6.1	3.4	3.8	6.1	4.4	1.7	9.6	17.7	10.4	7.3	152.6	190.2	136.4	329.4
1991	4.5	8.6	4.6	4	3	6.2	2.9	3.3	8.1	14.2	8.2	6	170.0	129.0	182.8	81.8
1992	5.7	10.2	6.6	3.6	4.4	6.7	4.4	2.3	8.9	18.7	12.1	6.6	102.3	179.1	175.0	187.0
1993	5.1	12	7	5	3.6	7.3	4.2	3.1	8.6	22.6	13.2	9.4	138.9	209.6	214.3	203.2
1994	4.9	9.6	5.9	3.7	5.2	6.4	4	2.4	4.1	17.3	10.7	6.6	-21.2	170.3	167.5	175.0
1995	4.6	7.9	4.6	3.3	3.3	6.6	3.5	3.1	6.7	11.6	7.6	4	103.0	75.8	117.1	29.0
1996	4.6	7.2	3.3	3.9	3.7	6	2.2	3.8	7	10.9	6.3	4.6	89.2	81.7	186.4	21.1
1997	4.8	8.6	4.8	3.8	3.3	6.9	4.9	2	8.5	13.2	4.8	8.4	157.6	91.3	-2.0	320.0
1998	5.4	8	5.4	2.6	3.2	5.5	3.4	2.1	9.7	13.3	9.4	3.9	203.1	141.8	176.5	85.7
1999	^	9.3	6.5	2.8	^	4.9	3.6	1.3	^	19.6	13.1	6.5	^	300.0	263.9	400.0
2000	^	10	5.5	4.6	^	5.6	2.3	3.3	^	19.9	12.4	7.6	^	255.4	439.1	130.3

*All rates are per 1,000 live births

^Data unavailable

¹Infant (under 1 year of age), Neonatal (under 28 days), Postneonatal (28-365 days)

²Race of mother

³Number of fetal deaths at 22 weeks gestation or more (or 500 grams or more) per 1,000 live births plus fetal deaths

⁴The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((black rate - white rate) / white rate) X 100.

Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 55. Infant Mortality Rates per 1,000 Live Births, and Numbers, by Race of Mother, for Tennessee and Selected Counties in Tennessee, 2000, and the U.S., 1999

County	All Races		White		Black		Disparity ¹
	Number	Rate	Number	Rate	Number	Rate	
Nashville	90	10	32	5.6	55	19.9	255.4
Hamilton	50	12.4	28	9.8	22	20.4	108.2
Knox	23	4.8	17	4.1	5	10.1	146.3
Shelby	200	13.6	43	7.4	155	18.1	144.6
Tennessee	719	9	408	6.6	305	18.1	174.2
U.S.	27,937	7.1	18067	5.8	8822	14.6	151.7

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((black rate - white rate)/ white rate) X 100. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 56. Neonatal Mortality Rates per 1,000 Live Births, and Numbers, by Race of Mother, for Tennessee and Selected Counties in Tennessee, 2000, and the U.S., 1999

County	All Races		White		Black		Disparity ¹
	Number	Rate	Number	Rate	Number	Rate	
Nashville	49	5.5	13	2.3	34	12.4	439.1
Hamilton	38	9.4	21	7.3	17	15.8	116.4
Knox	14	2.9	11	2.6	3	6.1	134.6
Shelby	138	9.4	35	6.1	102	11.9	95.1
Tennessee	466	5.9	260	4.3	202	12.0	179.1
U.S.	18,728	4.7	12164	3.9	5920	9.8	151.3

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((black rate - white rate)/ white rate) X 100. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 57. Postneonatal Mortality Rates per 1,000 Live Births, and Number, by Race of Mother, for Tennessee and Selected Counties in Tennessee, 2000, and the U.S., 1999

County	All Races		White		Black		Disparity ¹
	Number	Rate	Number	Rate	Number	Rate	
Nashville	41	4.6	19	3.3	21	7.6	130.3
Hamilton	12	3.0	7	2.4	5	4.6	91.7
Knox	9	1.9	6	1.4	2	4.0	185.7
Shelby	62	4.2	8	1.4	53	6.2	342.9
Tennessee	253	3.2	145	2.4	103	6.1	154.2
U.S.	9,209	2.3	5,903	1.9	2,902	4.8	152.6

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((black rate - white rate)/ white rate) X 100. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 58. Number and Percent¹ of Low Birth Weight² Births by Race and Age, Nashville, TN, 1990-2000

Year	All Races				White				Black				Disparity ³	
	All		10-19		All		10-19		All		10-19		All	10-19
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent		
1990	787	9.0	164	12.5	410	6.9	63	9	358	13.8	66	10.7	100.0	18.9
1991	764	8.8	125	9.3	373	6.4	50	7.3	381	14.2	54	8.5	121.9	16.4
1992	752	8.9	139	11.2	379	6.6	64	8.9	358	14.0	65	10.7	112.1	20.2
1993	787	9.4	144	11.2	387	7.0	57	9.5	386	14.6	60	9.0	108.6	-5.3
1994	793	9.7	158	12.6	427	7.7	74	11.7	350	14.4	80	13.1	87.0	12.0
1995	762	9.3	111	9.4	388	7.1	37	6.6	348	13.9	41	6.7	95.8	1.5
1996	765	9.3	144	11.3	400	6.7	54	8.6	327	13.6	88	13.9	103.0	61.6
1997	798	9.6	151	12.8	403	7.3	67	11.8	371	15.0	82	14.1	105.5	19.5
1998	830	9.8	170	13.6	409	7.3	67	10.6	388	15.2	101	17	108.2	60.4
1999	821	9.6	133	11.3	432	7.8	61	10.1	359	13.8	72	13.2	76.9	30.7
2000	821	9.1	129	11.2	388	6.8	57	10.1	397	14.3	70	12.7	110.3	25.7

Total may include events other than white or black.

¹Percentage of all live births

²Low birthweight is defined as less than 5 pounds and 8 ounces, or less than 2500 grams

³The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((% black - % white) / % white) X 100.

Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 59. Number and Percent¹ of Preterm² Births by Race and Age³, Nashville, TN, 1990-2000

Year	All Races				White				Black				Disparity ⁵	
	All		10-19		All		10-19		All		10-19		All	10-19
	Number	Percent ⁴	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent		
1990	902	10.7	176	13.6	548	9.5	77	11.6	336	13.1	97	15.7	37.9	35.3
1991	871	10.5	134	10.4	476	8.6	59	9.1	386	14.7	74	11.9	70.9	30.8
1992	854	10.5	158	13.1	496	9.1	77	13.2	336	13.4	78	13.0	47.3	-1.5
1993	927	11.4	157	12.6	522	9.8	63	10.8	395	15.2	93	14.2	55.1	31.5
1994	870	10.9	158	12.8	518	9.6	77	12.5	335	14.0	78	13.0	45.8	4.0
1995	825	10.3	125	10.9	454	8.6	43	7.9	346	14.2	81	13.8	65.1	74.7
1996	927	11.4	155	12.3	537	9.9	63	10.5	347	14.6	88	14.0	47.5	33.3
1997	985	11.8	168	14.3	579	10.5	67	11.9	384	15.5	100	17.3	47.6	45.4
1998	951	11.4	161	13.1	516	9.3	63	10.1	399	16.0	97	16.6	72.0	64.4
1999	1,076	12.6	159	13.5	606	11.0	67	11.1	429	16.5	89	16.3	50.0	46.8
2000	1,054	11.7	149	13.0	549	9.6	55	9.7	465	16.8	92	16.7	75.0	72.2

Total may include events with race other than white or black.

¹Percentage of all live births

²Born prior to 37 complete weeks of gestation

³Maternal race and age

⁴Calculated only for those whose weeks of gestation were known

⁵The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((% black - % white) / % white) X 100.

Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 60. Number and Percentage of Low Birth Weight Births by Race of Mother, for Tennessee and Selected Counties in Tennessee, 2000, and the U.S., 1999

County	All Races		White		Black		Disparity ¹
	Number	Percentage	Number	Percentage	Number	Percentage	
Nashville	821	9.1	388	6.8	397	14.3	110.3
Hamilton	478	11.9	282	9.9	188	17.4	75.8
Knox	406	8.5	335	8.0	63	12.8	60.0
Shelby	1,711	11.6	402	7.0	1,275	14.9	112.9
Tennessee	7,352	9.2	4,753	7.8	2,466	14.6	87.2
U.S.	307,030	7.6	208,818	6.5	80,778	13.1	101.5

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((% black - % white)/ % white) X 100. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

Data Table 61. Number and Percentage of Preterm Births by Race of Mother, for Tennessee and Selected Counties in Tennessee, 2000, and the U.S., 1999

County	All Races		White		Black		Disparity ¹
	Number	Percentage	Number	Percentage	Number	Percentage	
Nashville	821	9.1	388	6.8	397	14.3	110.3
Hamilton	478	11.9	282	9.9	188	17.4	75.8
Knox	406	8.5	335	8.0	63	12.8	60.0
Shelby	1,711	11.6	402	7.0	1,275	14.9	112.9
Tennessee	7,352	9.2	4,753	7.8	2,466	14.6	87.2
U.S.	307,030	7.6	208,818	6.5	80,778	13.1	101.5

Total may include events with race other than white or black.

¹The disparity is the percentage difference between whites and blacks. It is calculated as follows: ((% black - % white)/ % white) X 100. Negative numbers indicate a percentage decrease, and positive numbers indicate a percentage increase.

DataTable 62. Deaths by Age, Race, and Sex, Nashville, TN, 2000

Age	All Races			White			Black		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
All ages	5,048	2,406	2,642	3,747	1,758	1,989	1,254	621	633
< 1 year	90	55	35	32	19	13	55	35	20
1 - 4	14	5	9	5	2	3	9	3	6
5 - 9	11	7	4	6	3	3	5	4	1
10 - 14	14	9	5	7	6	1	7	3	4
15 - 19	46	35	11	28	21	7	18	14	4
20 - 24	53	39	14	33	24	9	20	15	5
25 - 29	75	49	26	34	23	11	36	22	14
30 - 34	73	52	21	43	32	11	28	18	10
35 - 39	107	73	34	64	45	19	42	27	15
40 - 44	147	94	53	87	58	29	60	36	24
45 - 49	186	122	64	111	74	37	71	45	26
50 - 54	215	132	83	148	90	58	66	41	25
55 - 59	246	152	94	162	98	64	80	51	29
60 - 64	298	175	123	202	127	75	90	45	45
65 - 69	387	192	195	291	138	153	92	51	41
70 - 74	508	259	249	393	207	186	112	50	62
75 - 79	644	308	336	523	262	261	118	45	73
80 - 84	682	299	383	546	248	298	132	51	81
85+	1,252	349	903	1032	281	751	213	65	148

Data Table 63. Crude Death Rates per 100,000 Population by Age, Race, and Sex, Nashville, TN, 2000

Age	All Races			White			Black		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
All ages	885.8	872.2	898.6	981.4	951.4	1,009.7	849.0	904.5	800.9
< 1 year	1,110.8	1,309.2	897.2	699.8	808.2	585.1	2,233.0	2,745.1	1,683.5
1 - 4	47.1	32.8	62.3	30.3	23.4	37.7	92.9	60.7	126.4
5 - 9	30.8	38.5	22.8	31.1	30.5	31.8	38.3	60.7	15.5
10 - 14	42.1	52.7	31.0	38.0	63.3	11.2	57.2	47.8	67.0
15 - 19	120.0	180.7	58.0	128.2	189.8	65.0	138.1	220.1	60.0
20 - 24	111.5	167.0	57.9	112.6	165.6	60.8	149.3	253.7	66.8
25 - 29	142.9	184.6	100.2	97.9	130.0	64.5	291.3	386.5	210.0
30 - 34	153.1	212.1	90.6	133.5	191.3	71.1	249.4	343.4	167.0
35 - 39	222.7	303.9	141.5	196.4	271.1	118.8	344.0	486.7	225.1
40 - 44	323.4	423.1	228.1	276.9	372.3	183.1	518.9	680.9	382.5
45 - 49	455.1	613.3	305.1	379.2	510.6	250.3	735.7	1,026.0	493.8
50 - 54	629.3	801.6	469.0	582.5	730.3	443.3	903.1	1,219.9	633.4
55 - 59	985.3	1,304.2	706.1	845.2	1,091.8	628.1	1,646.4	2,335.2	1,084.1
60 - 64	1,481.6	1,905.5	1,125.3	1,302.0	1,780.0	895.1	2,293.6	2,637.7	2,028.9
65 - 69	2,239.3	2,598.8	1,970.9	2,152.2	2,363.8	1,991.4	2,766.9	3,769.4	2,079.1
70 - 74	3,152.1	3,919.5	2,618.8	2,996.6	3,836.9	2,409.3	4,158.9	4,690.4	3,810.7
75 - 79	4,863.3	6,233.6	4,047.7	4,734.7	6,308.7	3,786.5	5,847.4	6,320.2	5,589.6
80 - 84	7,748.2	10,097.9	6,557.1	7,481.5	10,044.6	6,171.0	9,503.2	11,159.7	8,691.0
85+	15,646.1	17,511.3	15,027.5	15,586.8	16,978.9	15,122.8	16,537.3	21,311.5	15,056.0

Data Source: Tennessee Department of Health, October 8, 2001.

Data Table 64. Total Deaths by Planning District, Gender, Race, and Age, Nashville, TN, 1998

Planning District	Population	Total Deaths	Gender		Race		Age										
			Male	Female	White	Black	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
1	5,011	44	29	15	43	0	1	0	0	1	0	5	1	6	13	10	7
2	17,402	149	79	70	112	35	2	1	0	1	7	5	10	24	32	39	28
3	25,306	355	180	175	118	236	4	1	1	10	14	15	38	41	73	84	74
4	39,077	426	202	224	399	25	5	0	0	1	9	22	27	54	103	117	88
5	63,879	675	359	316	477	194	10	1	2	9	18	45	69	105	136	161	119
6	31,243	197	104	93	193	3	3	0	1	6	2	7	12	13	34	64	55
7a	12,375	105	59	46	87	17	2	1	0	2	2	5	13	15	26	21	18
7b	26,012	241	106	135	234	4	2	0	0	2	1	5	18	23	52	76	62
8	21,721	333	174	159	23	309	8	1	1	11	10	25	37	43	70	71	56
9	3,435	30	19	11	17	12	1	0	0	1	0	3	5	5	4	9	2
10a	30,802	260	117	143	111	148	2	0	0	4	5	9	19	28	46	64	83
10b	42,076	394	162	232	381	12	2	1	1	1	6	5	13	22	59	120	164
11	32,067	346	178	168	262	82	3	1	0	10	10	8	23	30	101	95	65
12	70,914	465	234	231	413	47	8	4	0	12	17	22	34	57	105	132	74
13	48,751	240	141	99	203	30	6	0	3	10	12	11	18	35	58	53	34
14	68,845	555	259	296	531	21	4	0	0	7	11	23	39	56	117	141	157
Unknown	0	81	45	36	69	12	6	0	0	1	4	5	6	11	16	16	16
Total	538,916	4,896	2,447	2,449	3,673	1,187	69	11	9	89	128	220	382	568	1,045	1,273	1,102

Data Table 65. Total Deaths by Council District, Gender, Race, and Age, Nashville, TN, 1998

Council District	Population	Total Deaths	Gender		Race		Age										
			Male	Female	White	Black	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
1	17,188	226	118	108	120	105	3	0	1	6	7	10	16	27	53	53	51
2	12,891	157	85	72	41	116	2	1	0	4	6	10	22	18	31	37	26
3	15,122	163	87	76	135	28	1	0	0	2	4	5	10	20	40	43	37
4	16,127	155	92	63	108	46	2	2	0	3	9	9	16	30	31	35	18
5	13,592	146	76	69	60	85	4	0	0	2	2	13	21	29	32	25	18
6	14,205	159	72	87	124	34	1	0	0	2	4	7	17	29	33	35	31
7	15,111	148	89	58	106	40	2	0	2	2	6	8	12	21	23	40	31
8	14,492	179	78	101	163	14	2	0	0	1	2	11	11	11	37	54	49
9	14,383	155	74	81	137	16	2	0	0	0	4	13	10	22	34	38	31
10	17,751	160	76	85	154	4	3	0	0	0	3	6	10	22	41	51	25
11	16,792	178	76	102	173	6	1	0	0	3	1	7	12	16	28	45	66
12	26,385	140	63	77	127	10	3	0	1	2	3	7	10	12	25	34	44
13	17,338	94	58	36	88	4	1	0	1	4	3	4	5	12	28	23	14
14	13,192	126	69	58	121	4	1	0	0	2	4	6	11	16	35	29	22
15	14,863	142	66	76	134	8	0	0	0	2	3	3	6	17	36	40	34
16	13,451	156	87	69	141	14	2	1	0	3	4	3	9	12	45	48	29
17	12,889	143	72	71	52	91	2	0	0	2	2	4	9	17	33	40	35
18	12,126	64	25	40	46	18	0	0	0	0	1	3	4	4	11	13	28
19	15,079	184	86	98	58	125	1	0	0	6	7	10	21	22	36	42	40
20	12,602	208	113	95	24	184	5	1	1	8	7	12	21	23	49	48	33
21	15,491	166	80	86	50	115	4	0	0	3	4	14	22	26	31	33	30
22	12,689	116	60	56	106	8	1	0	0	2	3	5	12	15	31	25	21
23	16,826	116	57	59	113	2	1	0	1	4	2	2	10	8	21	36	31
24	15,243	134	55	78	124	9	4	1	0	1	1	2	10	13	23	43	36
25	13,965	145	62	84	135	10	1	0	1	0	3	3	3	8	21	46	60
26	13,985	124	66	58	110	13	2	2	0	4	3	4	9	12	29	41	18
27	14,159	93	53	41	84	7	1	1	0	4	4	2	9	13	22	26	11
28	13,903	53	21	31	43	6	2	0	0	2	5	3	4	7	9	13	8
29	12,784	67	45	22	52	13	2	0	1	2	1	3	4	9	21	13	10
30	13,421	98	47	51	83	13	2	1	0	2	3	7	7	13	20	25	19
31	23,512	108	50	59	94	14	4	0	0	5	7	8	7	18	22	20	17
32	14,948	97	53	43	92	5	0	1	0	0	3	2	8	10	25	33	15
33	16,753	144	66	78	142	2	0	0	0	1	3	2	8	9	26	43	53
34	16,727	160	64	96	158	2	0	0	0	0	1	2	7	9	24	49	66
35	18,932	109	60	49	107	2	2	0	0	2	0	4	3	6	21	39	32
Unknown	0	81	49	32	65	16	6	0	0	1	4	5	6	11	16	16	16
Total	538,916	4,896	2,451	2,445	3,669	1,191	69	11	9	89	128	220	382	568	1,045	1,273	1,102

Data Table 66. Leading Causes of Death (and Number of Deaths) by Planning District, Nashville, TN, 1998

Joelton	Belshire/Union Hill	Bordeaux/ Whites Creek	Madison/Goodlettsville
Total Deaths 44 1. Heart Disease (13) 2. Cancer (11) 3. Stroke (4) 3. COPD* (4) 4. Accidents (3)	Total Deaths 149 1. Heart Disease (46) 2. Cancer (33) 3. Stroke (16) 4. COPD* (7) 5. Diabetes (6) 5. Homicide (6)	Total Deaths 355 1. Heart Disease (109) 2. Cancer (71) 3. Pneumonia & Influenza (24) 4. Stroke (18) 5. Homicide (15)	Total Deaths 426 1. Heart Disease (154) 2. Cancer (88) 3. Stroke (34) 4. Accidents (20) 5. Pneumonia & Influenza (15) 5. COPD* (15)

East Nashville/Inglewood	Bellevue	The Nations/Sylvan Park	Belle Meade/West Meade
Total Deaths 675 1. Heart Disease (203) 2. Cancer (163) 3. Pneumonia & Influenza (36) 3. COPD* (36) 4. Stroke (29)	Total Deaths 197 1. Heart Disease (52) 2. Cancer (49) 3. Stroke (20) 4. COPD* (11) 5. Accidents (7)	Total Deaths 105 1. Heart Disease (33) 2. Cancer (20) 3. Stroke (11) 4. Pneumonia & Influenza (5) 5. Accidents (4) 5. HIV/AIDS (4)	Total Deaths 241 1. Heart Disease (67) 2. Cancer (61) 3. Stroke (19) 4. Pneumonia & Influenza (13) 5. Accidents (10)

North Nashville	Downtown	West End/Vanderbilt	Forest Hills/Oak Hill
Total Deaths 333 1. Heart Disease (97) 2. Cancer (72) 3. Stroke (18) 4. Accidents (15) 4. Homicide (15)	Total Deaths 30 1. Cancer (7) 2. Heart Disease (6) 3. HIV/AIDS (3) 4. Pneumonia & Influenza (2) 4. Suicide (2) 4. Homicide (2)	Total Deaths 260 1. Heart Disease (70) 2. Cancer (64) 3. Stroke (18) 4. Diabetes (17) 5. Pneumonia & Influenza (15)	Total Deaths 394 1. Heart Disease (106) 2. Cancer (94) 3. Stroke (37) 4. Pneumonia & Influenza (22) 5. COPD* (17)

Berry Hill/Woodbine	Tusculum/Crieve Hall	Priest Lake/ Antioch	Donelson/Hermitage
Total Deaths 346 1. Heart Disease (97) 2. Cancer (76) 3. Pneumonia & Influenza (24) 4. Stroke (23) 4. COPD* (23)	Total Deaths 465 1. Heart Disease (138) 2. Cancer (126) 3. Stroke (28) 3. Accidents (28) 4. COPD* (24)	Total Deaths 240 1. Heart Disease (67) 2. Cancer (60) 3. Accidents (14) 4. COPD* (11) 5. Pneumonia & Influenza (10)	Total Deaths 555 1. Heart Disease (171) 2. Cancer (119) 3. Stroke (35) 4. Accidents (25) 5. COPD* (24)

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 67. Leading Causes of Death (and Number of Deaths) for Females by Planning Districts, Nashville, TN, 1998

Joelton	Belshire/Union Hill	Bordeaux/ Whites Creek	Madison/Goodlettsville
Total Deaths 15	Total Deaths 70	Total Deaths 175	Total Deaths 224
1. Heart Disease (4)	1. Heart Disease (20)	1. Heart Disease (57)	1. Heart Disease (84)
2. Cancer (3)	2. Stroke (11)	2. Cancer (31)	2. Cancer (41)
2. COPD* (3)	3. Cancer (10)	3. Stroke (12)	3. Stroke (19)
3. Accidents (2)	4. COPD* (6)	3. Pneumonia & Influenza (12)	4. Pneumonia & Influenza (11)
	5. Diabetes (4)	4. Diabetes (7)	5. Accidents (9)

East Nashville/Inglewood	Bellevue	The Nations/Sylvan Park	Belle Meade/West Meade
Total Deaths 316	Total Deaths 93	Total Deaths 46	Total Deaths 135
1. Heart Disease (97)	1. Cancer (26)	1. Heart Disease (19)	1. Cancer (37)
2. Cancer (69)	1. Heart Disease (26)	2. Cancer (11)	2. Heart Disease (36)
3. Stroke (20)	2. Stroke (10)	3. Stroke (6)	3. Stroke (12)
4. Pneumonia & Influenza (17)	3. COPD* (4)	4. Pneumonia & Influenza (2)	4. Pneumonia & Influenza (7)
5. Diabetes (12)	4. Diabetes (2)	4. Congenital Anomalies (2)	5. Accidents (6)
5. COPD* (12)	4. Atherosclerosis (2)		
	4. Pneumonia & Influenza (2)		
	4. Alzheimer's Disease (2)		

North Nashville	Downtown	West End/Vanderbilt	Forest Hills/Oak Hill
Total Deaths 159	Total Deaths 11	Total Deaths 143	Total Deaths 232
1. Heart Disease (52)	1. Heart Disease (4)	1. Heart Disease (37)	1. Cancer (59)
2. Cancer (39)	2. Cancer (3)	2. Cancer (29)	2. Heart Disease (58)
3. Stroke (7)		3. Stroke (14)	3. Stroke (23)
3. Diabetes (7)		4. Diabetes (13)	4. Pneumonia & Influenza (13)
4. COPD* (6)		5. Pneumonia & Influenza (11)	5. COPD* (13)

Berry Hill/Woodbine	Tusculum/Crieve Hall	Priest Lake/ Antioch	Donelson/Hermitage
Total Deaths 168	Total Deaths 231	Total Deaths 99	Total Deaths 296
1. Heart Disease (50)	1. Heart Disease (75)	1. Heart Disease (29)	1. Heart Disease (87)
2. Cancer (33)	2. Cancer (50)	2. Cancer (23)	2. Cancer (65)
3. Pneumonia & Influenza (21)	3. Stroke (17)	3. COPD* (6)	3. Stroke (23)
4. Stroke (16)	4. Diabetes (12)	4. Diabetes (4)	4. Atherosclerosis (13)
5. COPD* (10)	4. COPD* (12)	4. Stroke (4)	4. Pneumonia & Influenza (13)

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 68. Leading Causes of Death (and Number of Deaths) for Males by Planning Districts, Nashville, TN, 1998

Joelton	Belshire/Union Hill	Bordeaux/ Whites Creek	Madison/Goodlettsville
Total Deaths 29	Total Deaths 79	Total Deaths 180	Total Deaths 202
1. Heart Disease (9)	1. Heart Disease (26)	1. Heart Disease (52)	1. Heart Disease (70)
2. Cancer (8)	2. Cancer (23)	2. Cancer (40)	2. Cancer (47)
3. Stroke (3)	3. Stroke (5)	3. Pneumonia & Influenza (12)	3. Stroke (15)
4. Pneumonia & Influenza (2)	3. Homicide (5)	3. Homicide (12)	4. Accidents (11)
4. Homicide (2)	4. Pneumonia & Influenza (3)	4. COPD* (8)	5. COPD* (10)
	4. Suicide (3)	4. Accidents (8)	
		4. HIV/AIDS (8)	

East Nashville/Inglewood	Bellevue	The Nations/Sylvan Park	Belle Meade/West Meade
Total Deaths 359	Total Deaths 104	Total Deaths 59	Total Deaths 106
1. Heart Disease (106)	1. Heart Disease (26)	1. Heart Disease (14)	1. Heart Disease (31)
2. Cancer (94)	2. Cancer (23)	2. Cancer (9)	2. Cancer (24)
3. COPD* (24)	3. Stroke (10)	3. Stroke (5)	3. Stroke (7)
4. Pneumonia & Influenza (19)	4. COPD* (7)	4. Accidents (4)	4. Diabetes (6)
5. Accidents (18)	4. Accidents (7)	4. HIV/AIDS (4)	4. Pneumonia & Influenza (6)

North Nashville	Downtown	West End/Vanderbilt	Forest Hills/Oak Hill
Total Deaths 174	Total Deaths 19	Total Deaths 117	Total Deaths 162
1. Heart Disease (45)	1. Cancer (4)	1. Cancer (35)	1. Heart Disease (48)
2. Cancer (33)	2. HIV/AIDS (3)	2. Heart Disease (33)	2. Cancer (35)
3. Homicide (14)	3. Heart Disease (2)	3. Accidents (7)	3. Stroke (14)
4. Stroke (11)	3. Pneumonia & Influenza (2)	4. Diabetes (4)	4. Pneumonia & Influenza (9)
4. Accidents (11)	3. Suicide (2)	4. Stroke (4)	5. Accidents (8)
4. HIV/AIDS (11)	3. Homicide (2)	4. Pneumonia & Influenza (4)	

Berry Hill/Woodbine	Tusculum/Crieve Hall	Priest Lake/ Antioch	Donelson/Hermitage
Total Deaths 178	Total Deaths 234	Total Deaths 141	Total Deaths 259
1. Heart Disease (47)	1. Cancer (76)	1. Heart Disease (38)	1. Heart Disease (84)
2. Cancer (43)	2. Heart Disease (63)	2. Cancer (37)	2. Cancer (54)
3. COPD* (13)	3. Accidents (20)	3. Accidents (13)	3. COPD* (16)
4. Accidents (10)	4. COPD* (12)	4. Pneumonia & Influenza (7)	4. Accidents (16)
5. Homicide (8)	5. Stroke (11)	5. Suicide (6)	5. Stroke (12)

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 69. Leading Causes of Death (and Number of Deaths) for Blacks by Planning District, Nashville, TN, 1998

Joelton	Belshire/Union Hill	Bordeaux/ Whites Creek	Madison/Goodlettsville
Total Deaths 0	Total Deaths 35 1. Heart Disease (7) 2. Cancer (6) 3. Homicide (4) 4. Diabetes (3) 4. Stroke (3)	Total Deaths 236 1. Heart Disease (71) 2. Cancer (48) 3. Homicide (14) 4. Stroke (13) 5. Diabetes (12) 5. Pneumonia & Influenza (12)	Total Deaths 25 1. Cancer (5) 1. Heart Disease (5) 2. Stroke (2) 2. Accidents (2)

East Nashville/Inglewood	Bellevue	The Nations/Sylvan Park	Belle Meade/West Meade
Total Deaths 194 1. Heart Disease (52) 2. Cancer (42) 3. Pneumonia & Influenza (12) 3. Homicide (12) 4. Diabetes (11)	Total Deaths 3 1. Heart Disease (2)	Total Deaths 17 1. Heart Disease (5) 2. HIV/AIDS (3) 3. Cancer (2)	Total Deaths 4 1. Heart Disease (2) 1. Cancer (2)

North Nashville	Downtown	West End/Vanderbilt	Forest Hills/Oak Hill
Total Deaths 309 1. Heart Disease (88) 2. Cancer (66) 3. Stroke (18) 4. Accidents (15) 5. Homicide (14)	Total Deaths 12 1. Cancer (4) 2. HIV/AIDS (3)	Total Deaths 148 1. Cancer (42) 2. Heart Disease (37) 3. Diabetes (10) 3. Stroke (10) 4. Pneumonia & Influenza (9)	Total Deaths 12 1. Heart Disease (3) 2. Cancer (2) 2. Stroke (2)

Berry Hill/Woodbine	Tusculum/Crieve Hall	Priest Lake/ Antioch	Donelson/Hermitage
Total Deaths 82 1. Cancer (20) 2. Heart Disease (18) 3. Pneumonia & Influenza (8) 4. Stroke (5) 5. Accidents (4) 5. Homicide (4) 5. HIV/AIDS (4)	Total Deaths 47 1. Cancer (8) 2. Heart Disease (6) 2. Accidents (6) 3. Diabetes (3) 3. Pneumonia & Influenza (3) 3. COPD* (3) 3. Homicide (3)	Total Deaths 30 1. Cancer (9) 2. Heart Disease (6) 3. Homicide (3) 4. Stroke (2) 4. Pneumonia & Influenza (2)	Total Deaths 21 1. Cancer (7) 2. Heart Disease (4) 3. Homicide (2)

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 70. Leading Causes of Death (and Number of Deaths) for Whites by Planning District, Nashville, TN, 1998

Joelton	Belshire/Union Hill	Bordeaux/ Whites Creek	Madison/Goodlettsville
Total Deaths 43 1. Heart Disease (13) 2. Cancer (11) 3. Stroke (4) 4. COPD* (3) 4. Accidents (3)	Total Deaths 112 1. Heart Disease (38) 2. Cancer (27) 3. Stroke (13) 4. COPD* (5) 5. Suicide (3) 5. Diabetes (3)	Total Deaths 118 1. Heart Disease (38) 2. Cancer (23) 3. Pneumonia & Influenza (12) 4. COPD* (7) 5. Accidents (6)	Total Deaths 399 1. Heart Disease (147) 2. Cancer (83) 3. Stroke (32) 4. Accidents (18) 5. COPD* (15)

East Nashville/Inglewood	Bellevue	The Nations/Sylvan Park	Belle Meade/West Meade
Total Deaths 477 1. Heart Disease (151) 2. Cancer (120) 3. COPD* (30) 4. Pneumonia & Influenza (24) 5. Stroke (22)	Total Deaths 193 1. Heart Disease (50) 2. Cancer (48) 3. Stroke (20) 4. COPD* (11) 5. Accidents (7)	Total Deaths 87 1. Heart Disease (28) 2. Cancer (18) 3. Stroke (9) 4. Pneumonia & Influenza (5) 5. Accidents (4)	Total Deaths 234 1. Heart Disease (64) 2. Cancer (57) 3. Stroke (19) 4. Pneumonia & Influenza (13) 5. Accidents (10)

North Nashville	Downtown	West End/Vanderbilt	Forest Hills/Oak Hill
Total Deaths 23 1. Heart Disease (9) 2. Cancer (6)	Total Deaths 17 1. Heart Disease (5) 2. Cancer (2) 2. Suicide (2) 2. Pneumonia & Influenza (2)	Total Deaths 111 1. Heart Disease (33) 2. Cancer (22) 3. Stroke (8) 4. COPD* (7) 4. Diabetes (7)	Total Deaths 381 1. Heart Disease (103) 2. Cancer (92) 3. Stroke (35) 4. Pneumonia & Influenza (22) 5. COPD* (16)

Berry Hill/Woodbine	Tusculum/Crieve Hall	Priest Lake/ Antioch	Donelson/Hermitage
Total Deaths 262 1. Heart Disease (78) 2. Cancer (56) 3. COPD* (22) 4. Stroke (18) 5. Pneumonia & Influenza (16)	Total Deaths 413 1. Heart Disease (132) 2. Cancer (117) 3. Stroke (26) 4. COPD* (21) 5. Accidents (20)	Total Deaths 203 1. Heart Disease (60) 2. Cancer (50) 3. Accidents (13) 4. COPD* (10) 5. Diabetes (8) 5. Pneumonia & Influenza (8)	Total Deaths 531 1. Heart Disease (166) 2. Cancer (111) 3. Stroke (33) 4. Accidents (25) 5. COPD* (24)

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 71. Leading Causes of Death (and Number of Deaths) by Council Districts, Nashville, TN,
1998

1	2	3	4	5	6	7	8	9	10
Total Deaths 223 1. Heart disease (70) 2. Cancer (46) 3. Pneumonia & Influenza (12) 4. Accidents (12) 5. Stroke (11)	Total Deaths 150 1. Heart Disease (46) 2. Cancer (35) 3. Stroke (10) 4. Pneumonia and Influenza (7) 5. COPD* (7)	Total Deaths 162 1. Heart Disease (57) 2. Cancer (32) 3. Stroke (13) 4. COPD* (8) 4. Accidents (8)	Total Deaths 151 1. Heart Disease (48) 2. Cancer (39) 3. Stroke (10) 4. COPD* (6) 5. CLDC (5) 5. Accidents (5)	Total Deaths 143 1. Heart Disease (35) 2. Cancer (33) 3. Pneumonia & Influenza (7) 4. COPD* (7) 4. Accidents (7)	Total Deaths 163 1. Cancer (43) 2. Heart Disease (42) 3. Pneumonia & Influenza (9) 4. Stroke (9) 4. COPD* (9)	Total Deaths 150 1. Heart Disease (49) 2. Cancer (33) 3. COPD* (9) 4. Diabetes (7) 4. Pneumonia & Influenza (7)	Total Deaths 181 1. Heart Disease (66) 2. Cancer (35) 3. Stroke (12) 4. COPD* (8) 5. Pneumonia & Influenza (7)	Total Deaths 157 1. Heart Disease (58) 2. Cancer (31) 3. Stroke (14) 4. Accidents (9) 5. Pneumonia & Influenza (7)	Total Deaths 166 1. Heart Disease (54) 2. Cancer (39) 3. Stroke (13) 4. Homicide (8) 5. COPD* (7)
11	12	13	14	15	16	17	18	19	20
Total Deaths 177 1. Heart Disease (53) 2. Cancer (36) 3. Stroke (15) 4. Accidents (10) 5. Pneumonia & Influenza (5)	Total Deaths 141 1. Heart Disease (43) 2. Cancer (30) 3. Stroke (10) 4. Accidents (6) 5. COPD* (5) 5. Atherosclerosis (5)	Total Deaths 94 1. Heart Disease (27) 2. Cancer (24) 3. COPD* (5) 3. Accidents (5) 4. Stroke (4)	Total Deaths 126 1. Heart Disease (40) 2. Cancer (23) 3. Accidents (8) 4. Pneumonia & Influenza (5) 5. COPD* (5)	Total Deaths 148 1. Heart Disease (43) 2. Cancer (35) 3. COPD* (10) 4. Homicide (9) 5. Stroke (6)	Total Deaths 156 1. Heart Disease (46) 2. Cancer (34) 3. Stroke (11) 3. Pneumonia & Influenza (11) 3. COPD* (11)	Total Deaths 141 1. Heart Disease (41) 2. Cancer (34) 3. Diabetes (11) 4. Pneumonia & Influenza (8) 5. Stroke (8)	Total Deaths 65 1. Heart Disease (16) 2. Cancer (13) 3. Stroke (5) 4. COPD* (4) 4. Accidents (4)	Total Deaths 183 1. Heart Disease (50) 2. Cancer (43) 3. Stroke (14) 4. Pneumonia & Influenza (10) 5. Accidents (10)	Total Deaths 209 1. Heart Disease (64) 2. Cancer (43) 3. Stroke (10) 3. Homicide (10) 4. HIV/AIDS (9)
21	22	23	24	25	26	27	28	29	30
Total Deaths 163 1. Heart Disease (41) 2. Cancer (39) 3. Stroke (13) 4. Accidents (9) 5. HIV/AIDS (6)	Total Deaths 122 1. Heart Disease (32) 2. Cancer (26) 3. Stroke (8) 4. COPD* (7) 4. Homicide (7)	Total Deaths 116 1. Cancer (34) 2. Heart Disease (31) 3. Stroke (8) 4. Pneumonia & Influenza (6) 4. Accidents (6)	Total Deaths 134 1. Heart Disease (42) 2. Cancer (29) 3. Stroke (12) 4. Pneumonia & Influenza (5) 5. Accidents (5)	Total Deaths 145 1. Heart Disease (41) 2. Cancer (34) 3. Stroke (13) 4. Pneumonia & Influenza (6) 5. Accidents (6)	Total Deaths 123 1. Heart Disease (38) 2. Cancer (33) 3. COPD* (8) 4. Accidents (7) 5. Stroke (5)	Total Deaths 92 1. Heart Disease (27) 2. Cancer (26) 3. COPD* (6) 3. Accidents (6) 4. Diabetes (3) 4. Stroke (3) 4. Suicide (3)	Total Deaths 51 1. Heart Disease (15) 2. Cancer (10) 3. Diabetes (3) 3. COPD* (3) 3. Accidents (3)	Total Deaths 67 1. Cancer (20) 2. Heart Disease (15) 3. Pneumonia & Influenza (3) 4. COPD* (3) 4. Accidents (3)	Total Deaths 96 1. Heart Disease (30) 2. Cancer (23) 3. Stroke (6) 3. Accidents (6) 4. Diabetes (4) 4. Pneumonia & Influenza (4)
31	32	33	34	35					
Total Deaths 106 1. Heart Disease (30) 2. Cancer (26) 3. Accidents (9) 4. Diabetes (7) 5. Stroke (4) 5. COPD* (4)	Total Deaths 96 1. Cancer (32) 2. Heart Disease (29) 3. Stroke (10) 4. COPD* (6) 5. Accidents (3)	Total Deaths 147 1. Heart Disease (38) 2. Cancer (35) 3. Stroke (12) 4. Pneumonia & Influenza (7) 5. COPD* (7)	Total Deaths 160 1. Cancer (40) 2. Heart Disease (38) 3. Stroke (17) 4. Pneumonia & Influenza (8) 5. COPD* (8)	Total Deaths 109 1. Heart Disease (30) 2. Cancer (25) 3. Stroke (15) 4. COPD* (5) 5. Accidents (4)					

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 72. Leading Causes of Death (and Number of Deaths) for Males by Council Districts,
Nashville, TN, 1998

1	2	3	4	5	6	7	8	9	10
Total Deaths 118 1. Heart Disease (34) 2. Cancer (29) 3. Pneumonia & Influenza (10) 4. Homicide (7) 5. Accidents (6)	Total Deaths 85 1. Heart Disease (25) 2. Cancer (18) 3. Homicide (6) 4. COPD* (5)	Total Deaths 87 1. Heart Disease (29) 2. Cancer (19) 3. Stroke (6) 4. Accidents (6) 4. COPD* (5)	Total Deaths 92 1. Heart Disease (27) 2. Cancer (25) 3. CLDC (5) 3. Homicide (5) 4. Stroke (4) 4. COPD* (4)	Total Deaths 76 1. Cancer (21) 2. Heart Disease (17) 3. Pneumonia & Influenza (10) 4. COPD* (5) 4. Accidents (5)	Total Deaths 72 1. Cancer (22) 1. Heart Disease (22) 2. Pneumonia & Influenza (10) 3. COPD* (5) 3. Accidents (4)	Total Deaths 89 1. Heart Disease (29) 2. Cancer (20) 3. COPD* (7) 4. Accidents (5) 5. Diabetes (4)	Total Deaths 78 1. Heart Disease (27) 2. Cancer (14) 3. Stroke (5) 4. Pneumonia & Influenza (10) 4. COPD* (3) 4. Homicide (3)	Total Deaths 74 1. Heart Disease (27) 2. Cancer (16) 3. Stroke (5) 3. Accidents (5) 4. Diabetes (2) 4. Pneumonia & Influenza (2) 4. COPD* (2)	Total Deaths 76 1. Cancer (26) 1. Heart Disease (26) 2. COPD* (4) 3. Diabetes (3) 3. Stroke (3)

11	12	13	14	15	16	17	18	19	20
Total Deaths 76 1. Heart Disease (25) 2. Cancer (17) 3. Accidents (6) 4. COPD* (4) 5. Stroke (3) 5. Suicide (3)	Total Deaths 63 1. Heart Disease (22) 2. Cancer (15) 3. Accidents (4) 4. Stroke (2) 4. Pneumonia & Influenza (10) 4. COPD* (2) 4. Suicide (2)	Total Deaths 58 1. Heart Disease (16) 2. Cancer (15) 3. Accidents (5) 4. COPD* (3) 5. Pneumonia & Influenza (10) 5. Suicide (2) 5. Homicide (2)	Total Deaths 69 1. Heart Disease (23) 2. Cancer (11) 3. Accidents (5) 4. COPD* (4) 5. Pneumonia & Influenza (10)	Total Deaths 66 1. Heart Disease (20) 2. Cancer (13) 3. COPD* (6) 4. Stroke (4) 5. Suicide (3)	Total Deaths 87 1. Heart Disease (27) 2. Cancer (20) 3. COPD* (6) 4. Diabetes (5) 5. Stroke (4) 5. Accidents (4)	Total Deaths 72 1. Heart Disease (22) 2. Cancer (20) 3. Accidents (3) 3. Stroke (3) 3. Pneumonia & Influenza (3) 3. COPD* (3)	Total Deaths 25 1. Cancer (6) 1. Heart Disease (6)	Total Deaths 86 1. Cancer (24) 2. Heart Disease (17) 3. Accidents (8) 4. Homicide (7) 5. HIV/AIDS (6)	Total Deaths 112 1. Heart Disease (30) 2. Cancer (20) 3. Homicide (8) 3. HIV/AIDS (8) 4. Stroke (6)

21	22	23	24	25	26	27	28	29	30
Total Deaths 80 1. Heart Disease (17) 2. Cancer (16) 3. Accidents (8) 4. Homicide (6) 4. Stroke (6)	Total Deaths 60 1. Heart Disease (15) 2. Cancer (12) 3. Diabetes (4) 4. Stroke (3) 4. COPD* (3) 4. HIV/AIDS (3)	Total Deaths 57 1. Cancer (17) 2. Heart Disease (13) 3. Accidents (4) 4. Stroke (3) 4. COPD* (3)	Total Deaths 55 1. Heart Disease (16) 2. Cancer (11) 3. Stroke (7) 4. Accidents (3) 4. Pneumonia & Influenza (10)	Total Deaths 62 1. Heart Disease (18) 2. Cancer (12) 3. Pneumonia & Influenza (10) 4. Stroke (4) 4. Accidents (4)	Total Deaths 66 1. Cancer (22) 2. Heart Disease (16) 3. Accidents (5) 4. COPD* (4) 5. Suicide (2) 5. Stroke (2)	Total Deaths 53 1. Heart Disease (15) 2. Cancer (14) 3. Accidents (4) 3. COPD* (4) 4. Pneumonia & Influenza (2) 4. Diabetes (2) 4. Suicide (2) 4. Homicide (2)	Total Deaths 21 1. Cancer (6) 2. Heart Disease (5) 3. Accidents (2)	Total Deaths 45 1. Cancer (13) 2. Heart Disease (11) 3. Accidents (3) 3. Pneumonia & Influenza (2) 4. Alzheimer's Disease (2)	Total Deaths 47 1. Cancer (14) 2. Heart Disease (13) 3. Accidents (5) 4. Stroke (2) 4. COPD* (2) 4. Homicide (2)

31	32	33	34	35
Total Deaths 50 1. Cancer (15) 2. Heart Disease (12) 3. Accidents (7) 4. Homicide (3) 5. COPD* (2)	Total Deaths 53 1. Cancer (18) 2. Heart Disease (17) 3. Stroke (5) 4. COPD* (3) 5. Pneumonia & Influenza (10)	Total Deaths 66 1. Heart Disease (19) 2. Cancer (16) 3. Stroke (6) 4. Pneumonia & Influenza (10) 5. COPD* (2) 5. Accidents (2) 5. Suicide (2) 5. Congenital Anomalies (2)	Total Deaths 64 1. Heart Disease (18) 2. Cancer (13) 3. Stroke (5) 3. Pneumonia & Influenza (10) 4. COPD* (4)	Total Deaths 60 1. Heart Disease (19) 2. Cancer (12) 3. Stroke (8) 4. COPD* (4) 4. Accidents (4)

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 73. Leading Causes of Death (and Number of Deaths) for Females by Council Districts, Nashville, TN, 1998

1	2	3	4	5	6	7	8	9	10
Total Deaths 108 1. Heart Disease (36) 2. Cancer (17) 3. Pneumonia & Influenza (10) 4. COPD* (6) 4. Stroke (6) 4. Accidents (6)	Total Deaths 72 1. Heart Disease (22) 2. Cancer (16) 3. Stroke (6) 4. Pneumonia & Influenza (5) 5. Diabetes (2) 5. COPD* (2) 5. Homicide (2)	Total Deaths 76 1. Heart Disease (28) 2. Cancer (13) 3. Stroke (7) 4. Pneumonia & Influenza (5) 4. COPD* (3) 4. Diabetes (3)	Total Deaths 63 1. Heart Disease (21) 2. Cancer (14) 3. Stroke (6) 4. Diabetes (2) 4. COPD* (2) 4. Accidents (2)	Total Deaths 69 1. Heart Disease (18) 2. Cancer (12) 3. Stroke (3) 3. Pneumonia & Influenza (5) 3. Accidents (3) 3. Homicide (3)	Total Deaths 87 1. Cancer (21) 2. Heart Disease (20) 3. Pneumonia & Influenza (7) 3. Stroke (7) 4. Diabetes (4) 4. COPD* (4) 4. Accidents (4)	Total Deaths 58 1. Heart Disease (20) 2. Cancer (13) 3. Pneumonia & Influenza (3) 4. COPD* (3) 5. Diabetes (2) 5. Stroke (2) 5. CLDC (2) 5. Accidents (2)	Total Deaths 101 1. Heart Disease (31) 2. Cancer (21) 3. Stroke (7) 4. Diabetes (5) 4. COPD* (5)	Total Deaths 81 1. Heart Disease (31) 2. Cancer (15) 3. Stroke (10) 4. Pneumonia & Influenza (5) 5. Diabetes (3) 5. Accidents (3)	Total Deaths 85 1. Heart Disease (28) 2. Cancer (13) 3. Stroke (10) 4. Accidents (4) 5. Diabetes (3) 5. COPD* (3)

11	12	13	14	15	16	17	18	19	20
Total Deaths 102 1. Heart Disease (28) 2. Cancer (19) 3. Stroke (12) 4. Pneumonia & Influenza (5) 5. Atherosclerosis (6)	Total Deaths 77 1. Heart Disease (21) 2. Cancer (15) 3. Stroke (8) 4. Atherosclerosis (5) 5. COPD* (3)	Total Deaths 36 1. Heart Disease (11) 2. Cancer (9) 3. Pneumonia & Influenza (3) 3. COPD* (3) 4. Stroke (2)	Total Deaths 58 1. Heart Disease (17) 2. Cancer (12) 3. Pneumonia & Influenza (3) 4. Accidents (3) 5. Stroke (2) 5. Hypertension (2)	Total Deaths 76 1. Heart Disease (24) 2. Cancer (21) 3. COPD* (4) 4. Pneumonia & Influenza (3) 4. Stroke (2) 4. CLDC (2) 4. Hernia (2)	Total Deaths 69 1. Heart Disease (18) 2. Cancer (14) 3. Pneumonia & Influenza (7) 4. Stroke (7) 5. COPD* (5)	Total Deaths 71 1. Heart Disease (20) 2. Cancer (14) 3. Diabetes (8) 4. Pneumonia & Influenza (3) 5. Stroke (5)	Total Deaths 40 1. Heart Disease (11) 2. Cancer (7) 3. Stroke (3) 3. COPD* (3) 3. Accidents (3)	Total Deaths 98 1. Heart Disease (34) 2. Cancer (19) 3. Stroke (10) 4. Pneumonia & Influenza (5) 5. Diabetes (5)	Total Deaths 95 1. Heart Disease (33) 2. Cancer (23) 3. COPD* (5) 4. Diabetes (4) 4. Pneumonia & Influenza (2)

21	22	23	24	25	26	27	28	29	30
Total Deaths 86 1. Heart Disease (25) 2. Cancer (22) 3. Stroke (8) 4. Diabetes (4) 5. Congenital Anomalies (1)	Total Deaths 56 1. Heart Disease (17) 2. Cancer (14) 3. Stroke (5) 4. COPD* (4) 5. Pneumonia & Influenza (1)	Total Deaths 59 1. Cancer (18) 1. Heart Disease (18) 2. Stroke (5) 3. Pneumonia & Influenza (3) 4. COPD* (2) 4. Accidents (2)	Total Deaths 78 1. Heart Disease (26) 2. Cancer (18) 3. Stroke (5) 4. Pneumonia & Influenza (3) 5. Alzheimer's Disease (3)	Total Deaths 84 1. Heart Disease (24) 2. Cancer (22) 3. Stroke (9) 4. COPD* (4) 5. Pneumonia & Influenza (1)	Total Deaths 58 1. Heart Disease (22) 2. Cancer (11) 3. Stroke (4) 3. COPD* (4) 4. Pneumonia & Influenza (2)	Total Deaths 41 1. Cancer (12) 1. Heart Disease (12) 2. Stroke (2) 2. COPD* (2) 2. Accidents (2)	Total Deaths 31 1. Heart Disease (11) 2. Cancer (5) 3. Diabetes (2) 3. COPD* (2)	Total Deaths 22 1. Cancer (7) 2. Heart Disease (4) 3. Pneumonia & Influenza (2) 4. COPD* (2)	Total Deaths 51 1. Heart Disease (17) 2. Cancer (9) 3. Stroke (4) 3. Diabetes (4) 4. Pneumonia & Influenza (2)

31	32	33	34	35
Total Deaths 59 1. Heart Disease (18) 2. Cancer (12) 3. Diabetes (5) 4. Stroke (3) 5. COPD* (2) 5. Accidents (2) 5. Suicide (2) 5. Hypertension (2)	Total Deaths 43 1. Cancer (14) 2. Heart Disease (12) 3. Stroke (5) 4. COPD* (2) 4. Accidents (2)	Total Deaths 78 1. Cancer (19) 2. Heart Disease (18) 3. Stroke (6) 3. Pneumonia & Influenza (3) 4. COPD* (5)	Total Deaths 96 1. Cancer (27) 2. Heart Disease (21) 3. Stroke (13) 4. Pneumonia & Influenza (3) 5. COPD* (4) 5. Accidents (4)	Total Deaths 49 1. Cancer (14) 2. Heart Disease (12) 3. Stroke (7) 4. COPD* (2) 4. Atherosclerosis (2)

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 74. Leading Causes of Death (and Number of Deaths) for Whites by Council Districts, Nashville, TN, 1998

1	2	3	4	5	6	7	8	9	10
Total Deaths 120 1. Heart Disease (39) 2. Cancer (28) 3. Stroke (8) 3. Pneumonia & Influenza 4. COPD* (7) 4. Accidents (7)	Total Deaths 41 1. Heart Disease (11) 2. Cancer (7) 3. Pneumonia & Influenza 4. COPD* (4) 5. CLDC (2) 5. Accidents (2)	Total Deaths 135 1. Heart Disease (49) 2. Cancer (26) 3. Stroke (12) 4. COPD* (7) 5. Accidents (6)	Total Deaths 108 1. Heart Disease (36) 2. Cancer (29) 3. Stroke (7) 4. CLDC (5) 5. Accidents (3) 5. COPD* (3)	Total Deaths 60 1. Heart Disease (17) 2. Cancer (15) 3. COPD* (6) 4. Accidents (4) 5. Stroke (2) 5. Pneumonia & Influenza 5. CLDC (2) 5. Homicide (2) 5. Septicemia (2)	Total Deaths 124 1. Cancer (37) 2. Heart Disease (29) 3. Pneumonia & Influenza 4. COPD* (9) 5. Stroke (7)	Total Deaths 106 1. Heart Disease (37) 2. Cancer (21) 3. Pneumonia & Influenza 3. Accidents (6) 4. COPD* (5) 4. Stroke (5)	Total Deaths 163 1. Heart Disease (63) 2. Cancer (33) 3. Stroke (10) 4. COPD* (8) 5. Pneumonia & Influenza	Total Deaths 137 1. Heart Disease (53) 2. Cancer (29) 3. Stroke (12) 4. Accidents (7) 5. Pneumonia & Influenza	Total Deaths 154 1. Heart Disease (52) 2. Cancer (38) 3. Stroke (12) 4. COPD* (7) 5. Diabetes (6)

11	12	13	14	15	16	17	18	19	20
Total Deaths 173 1. Heart Disease (53) 2. Cancer (34) 3. Stroke (14) 4. Accidents (10) 5. Pneumonia & Influenza	Total Deaths 127 1. Heart Disease (39) 2. Cancer (25) 3. Stroke (10) 4. Accidents (6) 5. Atherosclerosis (5) 5. COPD* (5)	Total Deaths 88 1. Heart Disease (26) 2. Cancer (22) 3. COPD* (5) 3. Accidents (5) 4. Stroke (4) 4. Pneumonia & Influenza (4)	Total Deaths 121 1. Heart Disease (39) 2. Cancer (22) 3. Accidents (8) 4. Pneumonia & Influenza 5. COPD* (5)	Total Deaths 134 1. Heart Disease (43) 2. Cancer (33) 3. COPD* (10) 4. Stroke (6) 5. Pneumonia & Influenza	Total Deaths 141 1. Heart Disease (42) 2. Cancer (32) 3. Stroke (11) 4. COPD* (11) 4. Pneumonia & Influenza	Total Deaths 52 1. Heart Disease (18) 2. Cancer (9) 3. Diabetes (4) 4. COPD* (3) 5. Stroke (2) 5. Pneumonia & Influenza (2) 5. CLDC (2) 5. Accidents (2)	Total Deaths 46 1. Heart Disease (12) 2. Cancer (9) 3. COPD* (4) 4. Stroke (3) 4. Accidents (3)	Total Deaths 58 1. Heart Disease (19) 2. Cancer (8) 3. Pneumonia & Influenza 4. Stroke (4) 4. Diabetes (4) 4. COPD* (4)	Total Deaths 23 1. Heart Disease (8) 2. Cancer (6) 3. Suicide (3)

21	22	23	24	25	26	27	28	29	30
Total Deaths 50 1. Heart Disease (15) 2. Cancer (12) 3. Stroke (5) 4. Accidents (3) 5. Pneumonia & Influenza 5. COPD* (2)	Total Deaths 106 1. Heart Disease (29) 2. Cancer (22) 3. Stroke (7) 3. COPD* (7) 4. Diabetes (5)	Total Deaths 113 1. Cancer (33) 2. Heart Disease (30) 3. Stroke (8) 4. Pneumonia & Influenza 4. Accidents (6)	Total Deaths 124 1. Heart Disease (39) 2. Cancer (27) 3. Stroke (12) 4. Pneumonia & Influenza 5. Accidents (5)	Total Deaths 135 1. Heart Disease (39) 2. Cancer (33) 3. Stroke (12) 4. Pneumonia & Influenza 5. COPD* (5) 5. Accidents (5)	Total Deaths 110 1. Heart Disease (36) 2. Cancer (31) 3. COPD* (6) 4. Stroke (5) 4. Accidents (5)	Total Deaths 84 1. Heart Disease (26) 2. Cancer (24) 3. COPD* (6) 4. Accidents (5) 5. Diabetes (3) 5. Stroke (3)	Total Deaths 43 1. Heart Disease (13) 2. Cancer (9) 3. COPD* (3) 3. Accidents (3) 4. Diabetes (2)	Total Deaths 52 1. Cancer (15) 2. Heart Disease (13) 3. Pneumonia & Influenza 3. Accidents (3) 4. Stroke (2) 4. COPD* (2) 4. Alzheimer's Disease (2)	Total Deaths 83 1. Heart Disease (29) 2. Cancer (20) 3. Stroke (5) 4. Diabetes (4) 4. Accidents (4)

31	32	33	34	35
Total Deaths 94 1. Heart Disease (28) 2. Cancer (23) 3. Accidents (7) 4. Diabetes (5) 5. Stroke (4) 5. COPD* (4)	Total Deaths 92 1. Cancer (32) 2. Heart Disease (29) 3. Stroke (10) 4. COPD* (6) 5. Accidents (2)	Total Deaths 142 1. Heart Disease (37) 2. Cancer (35) 3. Stroke (12) 4. Pneumonia & Influenza 5. COPD* (7)	Total Deaths 158 1. Cancer (40) 2. Heart Disease (38) 3. Stroke (17) 4. Pneumonia & Influenza 5. COPD* (8)	Total Deaths 107 1. Heart Disease (29) 2. Cancer (24) 3. Stroke (15) 4. COPD* (5) 5. Accidents (4)

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 75. Leading Causes of Death (and Number of Deaths) for Blacks by Council Districts, Nashville, TN, 1998

1	2	3	4	5	6	7	8	9	10
Total Deaths 105 1. Heart Disease (31) 2. Cancer (18) 3. Pneumonia & Influenza (8) 4. Diabetes (7) 5. Accidents (5) 5. Homicide (5)	Total Deaths 116 1. Heart Disease (36) 2. Cancer (27) 3. Stroke (9) 4. Homicide (8) 5. Diabetes (4) 5. Pneumonia & Influenza (4) 5. HIV/AIDS (4)	Total Deaths 28 1. Heart Disease (8) 2. Cancer (6) 3. Homicide (3) 4. Accidents (2) 4. Diabetes (2)	Total Deaths 46 1. Heart Disease (12) 2. Cancer (11) 3. Homicide (5) 4. Stroke (3) 4. COPD* (3)	Total Deaths 85 1. Heart Disease (18) 2. Cancer (117) 3. Pneumonia & Influenza (8) 4. Homicide (5) 5. Diabetes (4)	Total Deaths 34 1. Heart Disease (12) 2. Cancer (6) 3. Diabetes (3) 4. Pneumonia & Influenza (2) 4. Accidents (2) 4. Congenital Anomalies (2)	Total Deaths 40 1. Heart Disease (12) 2. Cancer (11) 3. Diabetes (4) 3. COPD* (4) 4. CLDC (2) 4. Homicide (2)	Total Deaths 14 1. Heart Disease (3) 2. Cancer (2) 2. Stroke (2) 2. Homicide (2)	Total Deaths 16 1. Heart Disease (3) 2. Cancer (2) 2. Stroke (2) 2. Accidents (2)	Total Deaths 4 Data not Reportable^

11	12	13	14	15	16	17	18	19	20
Total Deaths 6 1. Cancer (2)	Total Deaths 10 1. Cancer (4) 2. Heart Disease (3)	Total Deaths 4 Data not Reportable^	Total Deaths 4 Data not Reportable^	Total Deaths 8 1. Cancer (2) 1. Homicide (2)	Total Deaths 14 1. Pneumonia & Influenza (4) 2. Heart Disease (3) 3. Cancer (2)	Total Deaths 91 1. Cancer (25) 2. Heart Disease (23) 3. Pneumonia & Influenza (7) 4. Diabetes (6) 5. Stroke (5)	Total Deaths 18 1. Cancer (5) 2. Heart Disease (4) 3. Stroke (2)	Total Deaths 125 1. Cancer (34) 2. Heart Disease (31) 3. Stroke (10) 4. Accidents (7) 4. Homicide (7) 4. HIV/AIDS (7)	Total Deaths 184 1. Heart Disease (56) 2. Cancer (37) 3. Stroke (10) 4. HIV/AIDS (9) 5. Homicide (7) 5. COPD* (7) 5. Accidents (7)

21	22	23	24	25	26	27	28	29	30
Total Deaths 115 1. Cancer (27) 1. Heart Disease (27) 2. Stroke (8) 3. Accidents (6) 3. Homicide (6)	Total Deaths 8 1. Heart Disease (3) 2. Cancer (2) 2. HIV/AIDS (2) 3. Stroke (1)	Total Deaths 2 Data not Reportable^	Total Deaths 9 1. Heart Disease (2)	Total Deaths 10 1. Heart Disease (3)	Total Deaths 13 1. Cancer (2) 1. Heart Disease (2) 1. COPD* (2)	Total Deaths 7 1. Cancer (2)	Total Deaths 6 1. Heart Disease (2) 1. Stroke (2)	Total Deaths 13 1. Cancer (4) 2. Heart Disease (3) 3. Pneumonia & Influenza (2)	Total Deaths 13 1. Cancer (2) 1. Accidents (2)

31	32	33	34	35
Total Deaths 14 1. Cancer (3) 2. Diabetes (2) 2. Heart Disease (2) 2. Accidents (2)	Total Deaths 5 Data not Reportable^	Total Deaths 2 Data not Reportable^	Total Deaths 2 Data not Reportable^	Total Deaths 2 Data not Reportable^

^ Data is not reportable when only single deaths occurred for each cause of death.

* COPD=Chronic Obstructive Pulmonary Disorder, as of 1999 called Chronic Lower Respiratory Disease.

Data Table 76. Years of Potential Life Lost by Planning District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Planning District																
		1	2	3	4	5	6	7a	7b	8	9	10a	10b	11	12	13	14	unknown
Chronic Obstructive Pulmonary Disease or Chronic Lower Respiratory Disease	White	5.0	16.7	11.4	43.0	138.0	12.4	31.0	30.6	11.5	0.0	30.5	22.0	91.2	49.5	119.6	126.2	11.0
	Black	0.0	1.0	55.0	0.0	27.0	0.0	5.3	0.0	52.2	0.0	0.0	5.5	5.5	67.5	0.0	0.0	0.0
	Male	0.0	6.9	44.6	22.0	75.5	12.4	36.3	9.6	15.7	0.0	11.0	0.0	59.8	38.5	63.3	87.8	5.5
	Female	5.0	10.8	21.8	21.0	89.5	0.0	0.0	21.0	48.0	0.0	19.5	27.5	36.9	78.5	56.2	38.4	5.5
	White male	0.0	5.9	5.1	22.0	48.5	12.4	31.0	9.6	0.0	0.0	11.0	0.0	54.3	38.5	63.3	87.8	5.5
	White female	5.0	10.8	6.3	21.0	89.5	0.0	0.0	21.0	11.5	0.0	19.5	22.0	36.9	11.0	56.2	38.4	5.5
	Black male	0.0	1.0	39.5	0.0	27.0	0.0	5.3	0.0	15.7	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0
	Black female	0.0	0.0	15.5	0.0	0.0	0.0	0.0	0.0	36.5	0.0	0.0	5.5	0.0	67.5	0.0	0.0	0.0
Accidents	White	113.0	9.4	172.2	376.0	290.0	311.6	66.5	172.2	0.0	25.5	81.0	211.4	396.6	698.2	391.7	635.7	132.0
	Black	0.0	82.0	111.0	81.0	163.0	0.0	0.0	0.0	319.4	0.0	212.2	67.5	162.9	137.5	35.5	0.0	45.5
	Male	32.0	19.0	209.1	390.5	437.5	293.2	66.5	37.7	167.4	25.5	267.7	172.5	499.1	733.6	391.1	478.2	162.0
	Female	81.0	87.6	74.4	66.5	96.5	18.5	0.0	134.5	152.0	0.0	25.5	106.4	60.4	203.1	36.1	157.5	0.0
	White male	32.0	9.4	112.2	309.5	229.0	293.2	66.5	37.7	0.0	25.5	55.5	105.0	336.2	495.1	355.6	478.2	116.5
	White female	81.0	0.0	60.0	66.5	61.0	18.5	0.0	134.5	0.0	0.0	25.5	106.4	60.4	203.1	36.1	157.5	15.5
	Black male	0.0	9.6	96.9	81.0	127.5	0.0	0.0	0.0	167.4	0.0	212.2	67.5	162.9	137.5	35.5	0.0	45.5
	Black female	0.0	72.4	14.1	0.0	35.5	0.0	0.0	0.0	152.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Diabetes Mellitus	White	5.0	5.4	0.7	125.0	156.8	16.9	0.0	122.6	0.0	8.2	82.7	5.5	56.3	104.0	54.5	26.5	25.5
	Black	0.0	23.5	110.8	0.0	118.2	0.0	0.0	0.0	53.0	0.0	47.5	0.0	5.5	5.5	0.0	35.5	0.0
	Male	0.0	0.8	19.7	47.5	151.7	1.4	0.0	91.6	36.5	8.2	52.0	0.0	53.0	5.5	51.1	16.4	0.0
	Female	5.0	28.0	91.7	77.5	123.3	15.5	0.0	31.0	16.5	0.0	78.2	5.5	8.8	104.0	8.0	46.5	25.5
	White male	0.0	0.0	0.0	47.5	74.8	1.4	0.0	91.6	0.0	8.2	15.5	0.0	47.5	5.5	46.5	15.5	0.0
	White female	5.0	5.4	0.7	77.5	82.0	15.5	0.0	31.0	0.0	0.0	67.2	5.5	8.8	98.5	8.0	11.0	25.5
	Black male	0.0	0.8	19.7	0.0	76.9	0.0	0.0	0.0	36.5	0.0	36.5	0.0	5.5	0.0	0.0	0.0	0.0
	Black female	0.0	22.6	91.1	0.0	41.3	0.0	0.0	0.0	16.5	0.0	11.0	0.0	0.0	5.5	0.0	35.5	0.0
Homicide	White	81.9	5.4	44.7	71.0	167.5	0.0	14.9	15.5	0.6	0.0	35.5	0.0	189.8	237.5	89.7	50.0	35.5
	Black	0.0	197.9	594.5	35.5	532.6	0.0	24.5	0.0	587.2	55.5	210.9	25.5	202.9	146.5	147.6	89.9	0.0
	Male	81.9	192.0	530.4	71.0	560.8	0.0	24.5	15.5	558.2	55.5	185.4	0.0	337.2	348.5	190.7	95.5	0.0
	Female	0.0	11.3	108.9	35.5	139.3	0.0	14.9	0.0	75.1	0.0	61.0	25.5	55.5	35.5	92.1	44.4	35.5
	White male	81.9	0.0	44.6	71.0	91.0	0.0	0.0	15.5	0.0	0.0	0.0	0.0	189.8	202.0	89.7	50.0	0.0
	White female	0.0	5.4	0.1	0.0	76.5	0.0	14.9	0.0	0.6	0.0	35.5	0.0	0.0	35.5	0.0	0.0	35.5
	Black male	0.0	192.0	485.8	0.0	469.8	0.0	24.5	0.0	512.7	55.5	185.4	0.0	147.4	146.5	101.0	45.5	0.0
	Black female	0.0	5.9	108.7	35.5	62.8	0.0	0.0	0.0	74.5	0.0	25.5	25.5	55.5	0.0	46.6	44.4	0.0
Chronic Liver Disease and Cirrhosis	White	0.0	31.0	81.0	25.5	194.0	0.0	11.0	0.0	0.0	0.0	5.5	5.5	106.0	57.5	18.4	60.6	15.5
	Black	0.0	1.0	49.5	0.0	107.0	0.0	0.0	0.0	132.6	0.0	14.9	0.0	0.0	0.0	0.0	0.0	0.0
	Male	0.0	32.0	95.0	0.0	169.0	0.0	11.0	0.0	26.1	0.0	14.9	0.0	39.5	46.5	17.0	11.0	15.5
	Female	0.0	0.0	35.5	25.5	132.0	0.0	0.0	0.0	106.5	0.0	5.5	5.5	66.5	11.0	1.4	49.6	0.0
	White male	0.0	31.0	45.5	0.0	168.5	0.0	11.0	0.0	0.0	0.0	0.0	0.0	39.5	46.5	17.0	11.0	15.5
	White female	0.0	0.0	35.5	25.5	25.5	0.0	0.0	0.0	0.0	0.0	5.5	5.5	66.5	11.0	1.4	49.6	0.0
	Black male	0.0	1.0	49.5	0.0	0.5	0.0	0.0	0.0	26.1	0.0	14.9	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	0.0	0.0	0.0	0.0	106.5	0.0	0.0	0.0	106.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Suicide	White	5.0	55.1	52.0	92.0	213.0	67.2	61.0	26.2	0.0	41.0	35.5	170.6	195.3	329.5	174.2	278.5	132.0
	Black	0.0	4.1	41.4	0.0	0.0	0.0	53.3	0.0	93.2	0.0	15.3	15.5	35.7	0.0	55.5	0.0	0.0
	Male	5.0	54.2	42.9	41.0	213.0	67.2	114.3	26.2	57.7	41.0	50.8	105.1	146.1	132.0	197.9	238.7	132.0
	Female	0.0	5.0	50.5	51.0	0.0	0.0	0.0	0.0	35.5	0.0	0.0	81.0	84.9	197.5	61.6	45.5	0.0
	White male	5.0	50.1	1.5	41.0	213.0	67.2	61.0	26.2	0.0	41.0	35.5	89.6	145.9	132.0	168.1	233.0	132.0
	White female	0.0	5.0	50.5	51.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	81.0	49.4	197.5	6.1	45.5	0.0
	Black male	0.0	4.1	41.4	0.0	0.0	0.0	53.3	0.0	57.7	0.0	15.3	15.5	0.2	0.0	0.0	0.0	0.0
	Black female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	35.5	0.0	0.0	0.0	35.5	0.0	55.5	0.0	0.0

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Data Table 76. Years of Potential Life Lost by Planning District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Planning District																
		1	2	3	4	5	6	7a	7b	8	9	10a	10b	11	12	13	14	unknown
Hypertension	White	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black	0.0	1.0	29.5	0.0	26.0	0.0	0.0	0.0	22.0	0.0	0.0	0.0	25.5	0.0	0.0	0.0	0.0
	Male	0.0	1.0	24.0	0.0	0.5	0.0	0.0	5.5	22.0	0.0	0.0	0.0	25.5	0.0	0.0	0.0	0.0
	Female	0.0	0.0	5.5	0.0	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White female																	
	Black male	0.0	1.0	24.0	0.0	0.5	0.0	0.0	0.0	22.0	0.0	0.0	0.0	25.5	0.0	0.0	0.0	0.0
	Black female	0.0	0.0	5.5	0.0	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Atherosclerosis	White	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	15.5	0.0
	Black	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	15.5	0.0
	White male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	15.5	0.0
	Black male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Congenital Anomalies	White	0.0	0.0	0.0	0.0	142.0	0.0	149.0	0.0	55.5	0.0	0.0	40.3	0.0	68.2	62.6	47.4	0.0
	Black	0.0	0.0	55.5	0.0	210.0	0.0	0.0	0.0	244.7	74.5	94.9	0.0	0.5	123.0	3.0	71.5	0.0
	Male	0.0	0.0	55.5	0.0	67.5	0.0	0.0	0.0	163.5	0.0	41.0	40.3	0.0	0.7	3.0	107.0	0.0
	Female	0.0	0.0	0.0	0.0	284.5	0.0	149.0	0.0	136.6	74.5	53.9	0.0	0.5	190.5	137.1	11.9	0.0
	White male	0.0	0.0	0.0	0.0	67.5	0.0	0.0	0.0	55.5	0.0	0.0	40.3	0.0	0.7	0.0	35.5	0.0
	White female	0.0	0.0	0.0	0.0	74.5	0.0	149.0	0.0	0.0	0.0	0.0	0.0	0.0	67.5	74.5	0.0	0.0
	Black male	0.0	0.0	55.5	0.0	0.0	0.0	0.0	0.0	108.0	0.0	41.0	0.0	0.0	0.0	3.0	71.5	0.0
	Black female	0.0	0.0	0.0	0.0	210.0	0.0	0.0	0.0	136.6	74.5	53.9	0.0	0.5	123.0	0.0	0.0	0.0
Alzheimer's Disease	White	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black	0.0	0.5	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.5	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	0.0	0.5	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HIV/AIDS	White	0.0	1.4	78.9	35.5	188.2	57.2	45.5	0.7	0.0	0.0	35.5	13.1	45.5	31.0	0.0	35.5	0.0
	Black	0.0	2.8	254.2	0.0	113.4	0.0	95.5	0.0	417.7	96.5	69.9	0.0	112.4	0.0	0.0	0.0	0.0
	Male	0.0	4.3	297.6	35.5	240.6	57.2	141.0	0.7	345.6	96.5	96.5	13.1	96.9	31.0	0.0	35.5	0.0
	Female	0.0	0.0	35.5	0.0	61.0	0.0	0.0	0.0	72.1	0.0	8.9	0.0	61.0	0.0	0.0	0.0	0.0
	White male	0.0	1.4	78.9	35.5	162.7	57.2	45.5	0.7	0.0	0.0	35.5	13.1	0.0	31.0	0.0	35.5	0.0
	White female	0.0	0.0	0.0	0.0	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	45.5	0.0	0.0	0.0	0.0
	Black male	0.0	2.8	218.7	0.0	77.9	0.0	95.5	0.0	345.6	96.5	61.0	0.0	96.9	0.0	0.0	0.0	0.0
	Black female	0.0	0.0	35.5	0.0	35.5	0.0	0.0	0.0	72.1	0.0	8.9	0.0	15.5	0.0	0.0	0.0	0.0
Prenatal Conditions	White	0.0	73.0	1.5	149.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	149.0	136.3	74.5	78.2	232.4	0.0
	Black	0.0	84.2	212.3	149.0	150.5	0.0	0.0	0.0	223.5	0.0	74.5	0.0	0.0	223.5	62.6	11.9	149.0
	Male	0.0	150.5	146.0	149.0	150.5	74.5	0.0	0.0	149.0	0.0	74.5	74.5	74.5	149.0	3.0	71.5	74.5
	Female	0.0	6.7	67.8	149.0	0.0	0.0	0.0	0.0	74.5	0.0	0.0	74.5	61.8	223.5	137.8	172.8	74.5
	White male	0.0	73.0	1.5	74.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	74.5	74.5	74.5	3.0	71.5	0.0
	White female	0.0	0.0	0.0	74.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	74.5	61.8	0.0	75.2	160.9	0.0
	Black male	0.0	77.5	144.5	74.5	150.5	0.0	0.0	0.0	149.0	0.0	74.5	0.0	0.0	0.0	0.0	0.0	74.5
	Black female	0.0	6.7	67.8	74.5	0.0	0.0	0.0	0.0	74.5	0.0	0.0	0.0	0.0	223.5	62.6	11.9	74.5
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Data Table 76. Years of Potential Life Lost by Planning District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Planning District																
		1	2	3	4	5	6	7a	7b	8	9	10a	10b	11	12	13	14	unknown
Heart Disease	White	107.6	191.2	315.6	925.0	1117.1	254.2	201.9	232.8	27.1	63.6	146.9	188.0	319.1	780.0	366.4	751.5	135.0
	Black	0.0	164.5	480.8	56.5	622.7	31.0	91.0	5.5	611.7	9.4	225.4	5.5	147.0	72.0	118.3	125.7	31.0
	Male	83.7	311.6	554.4	582.0	1188.8	133.8	190.5	167.7	405.6	73.0	278.9	130.9	246.7	550.0	308.0	665.4	190.5
	Female	23.9	89.5	196.6	460.5	551.1	151.3	102.4	96.1	233.2	0.0	93.4	62.6	224.0	266.5	193.4	217.1	11.0
	White male	83.7	167.0	192.3	490.0	724.0	128.3	124.0	162.2	21.0	63.6	115.9	125.4	230.1	534.5	236.4	594.0	124.0
	White female	23.9	69.6	77.9	435.0	393.1	125.8	77.9	70.6	6.1	0.0	31.0	62.6	89.0	245.5	130.1	157.5	11.0
	Black male	0.0	144.6	362.1	56.5	464.8	5.5	66.5	5.5	384.6	9.4	163.0	5.5	16.5	51.0	71.4	66.1	31.0
	Black female	0.0	19.9	118.7	0.0	158.0	25.5	24.5	0.0	227.1	0.0	62.4	0.0	130.5	21.0	46.9	59.6	0.0
Stroke	White	18.9	36.7	12.9	120.5	68.5	20.2	36.5	47.3	0.0	15.5	0.0	57.5	74.9	99.5	101.4	37.3	21.0
	Black	0.0	43.5	104.9	0.0	77.5	0.0	5.5	0.0	110.0	0.0	50.2	5.5	46.8	25.5	25.5	0.0	0.0
	Male	18.9	37.5	62.6	88.5	21.5	20.2	31.0	26.3	42.0	15.5	5.5	57.5	41.0	26.5	56.7	31.8	15.5
	Female	0.0	42.7	55.3	32.0	140.0	0.0	16.5	21.0	68.0	0.0	44.7	5.5	80.7	98.5	70.1	21.0	5.5
	White male	18.9	21.0	7.6	88.5	21.0	11.0	25.5	0.0	0.0	15.5	0.0	16.5	25.5	62.0	31.2	16.3	15.5
	White female	0.0	15.7	5.3	32.0	47.5	9.2	11.0	47.3	0.0	0.0	0.0	41.0	49.4	37.5	70.1	21.0	5.5
	Black male	0.0	16.5	55.0	0.0	0.5	0.0	0.0	0.0	77.5	0.0	5.5	5.5	15.5	0.0	25.5	0.0	0.0
	Black female	0.0	27.0	50.0	0.0	77.0	0.0	5.5	0.0	32.5	0.0	44.7	0.0	31.3	25.5	0.0	0.0	0.0
Cancer	White	69.8	189.8	214.6	642.5	885.4	441.3	128.9	387.6	102.6	14.9	139.1	630.8	377.3	1029.2	600.8	1113.5	139.5
	Black	0.0	76.2	445.5	97.5	521.9	5.5	5.5	15.5	613.9	40.0	390.5	5.5	146.6	178.5	174.2	67.3	25.5
	Male	69.8	168.3	368.3	376.0	910.1	208.5	46.5	215.1	317.2	50.0	176.1	257.7	359.7	735.6	466.2	651.8	52.0
	Female	27.9	94.8	266.6	364.0	564.7	238.3	87.9	193.5	399.3	30.4	353.5	378.6	164.2	487.6	332.0	576.7	113.0
	White male	69.8	134.2	109.0	329.5	472.0	208.5	41.0	209.6	51.0	0.0	46.5	257.7	260.0	623.6	351.7	586.8	52.0
	White female	27.9	52.7	80.5	313.0	413.4	232.8	87.9	178.0	51.6	14.9	92.6	373.1	117.3	405.6	249.1	526.6	87.5
	Black male	0.0	34.1	259.3	46.5	370.6	0.0	5.5	0.0	266.2	24.5	129.6	0.0	99.7	96.5	93.1	60.9	0.0
	Black female	0.0	42.1	186.2	51.0	151.3	5.5	0.0	15.5	347.7	15.5	260.9	5.5	46.9	82.0	81.1	6.4	25.5
Pneumonia & Influenza	White	0.0	18.4	37.8	15.5	108.8	6.6	35.9	18.9	0.6	15.5	0.0	15.5	15.6	21.0	6.4	26.5	74.5
	Black	0.0	8.2	114.5	5.5	169.9	0.0	0.0	0.0	15.5	0.0	16.4	0.0	0.1	0.0	11.0	15.5	0.0
	Male	0.0	26.6	146.7	5.5	176.7	0.0	20.4	0.0	16.1	15.5	15.5	15.5	5.5	0.0	16.5	31.0	74.5
	Female	0.0	0.0	5.5	15.5	102.0	6.6	15.5	18.9	0.0	0.0	11.0	0.0	15.6	21.0	0.9	11.0	0.0
	White male	0.0	18.4	37.8	0.0	57.8	0.0	20.4	0.0	0.6	15.5	0.0	15.5	5.5	0.0	5.5	15.5	74.5
	White female	0.0	0.0	0.0	15.5	51.0	6.6	15.5	18.9	0.0	0.0	0.0	0.0	10.1	21.0	0.9	11.0	0.0
	Black male	0.0	8.2	109.0	5.5	118.9	0.0	0.0	0.0	15.5	0.0	0.0	0.0	0.0	0.0	11.0	15.5	0.0
	Black female	0.0	0.0	5.5	0.0	51.0	0.0	0.0	0.0	0.0	0.0	16.4	0.0	0.1	0.0	0.0	0.0	0.0

Data Table 77. Years of Potential Life Lost by Council District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Council District																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Chronic Obstructive Pulmonary Disease or Chronic Lower Respiratory Disease	White	12.4	6.7	8.8	12.8	18.8	38.2	24.6	45.7	9.4	36.7	18.4	43.1	30.4	23.4	49.0	55.8	8.8	11.7
	Black	14.3	40.9	0.5	0.5	0.0	0.0	26.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	1.8	0.0
	Male	11.3	35.5	7.0	11.8	14.0	10.5	32.6	5.0	5.2	16.1	11.0	36.6	30.4	17.7	27.5	31.8	4.3	7.7
	Female	15.4	12.1	2.3	1.5	4.8	27.7	18.5	40.7	4.2	20.7	7.4	6.5	0.0	5.7	21.5	26.0	6.3	4.0
	White male	4.1	2.8	6.5	11.3	14.0	10.5	6.1	5.0	5.2	16.1	11.0	36.6	30.4	17.7	27.5	31.8	4.3	7.7
	White female	8.3	3.9	2.3	1.5	4.8	27.7	18.5	40.7	4.2	20.7	7.4	6.5	0.0	5.7	21.5	24.0	4.5	4.0
	Black male	7.1	32.7	0.5	0.5	0.0	0.0	26.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	7.1	8.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	1.8	0.0
Accidents	White	244.4	30.5	187.5	80.6	64.5	100.5	57.5	4.8	127.4	62.8	273.1	176.3	215.5	159.5	38.3	202.2	0.0	33.9
	Black	89.1	0.0	45.0	58.9	87.9	62.4	12.8	0.0	81.0	0.0	0.0	0.0	0.0	0.0	3.2	19.5	106.7	31.6
	Male	183.4	24.5	218.3	116.1	132.9	101.9	70.2	35.5	151.3	165.0	102.2	160.5	215.5	103.2	16.0	174.4	106.7	41.0
	Female	152.6	6.0	21.8	68.9	19.5	61.0	0.0	4.8	57.1	14.3	59.9	15.8	0.0	56.3	25.5	47.3	0.0	24.5
	White male	105.6	24.5	189.5	70.6	45.0	75.0	57.5	0.0	70.3	165.0	102.2	160.5	215.5	103.2	12.8	154.9	0.0	9.4
	White female	141.0	6.0	4.6	9.9	19.5	25.5	0.0	4.8	57.1	0.0	59.9	15.8	0.0	56.3	25.5	47.3	0.0	24.5
	Black male	77.7	0.0	28.8	0.0	87.9	26.9	12.8	0.0	81.0	0.0	0.0	0.0	0.0	0.0	3.2	19.5	106.7	31.6
	Black female	11.3	0.0	16.3	58.9	0.0	35.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Diabetes Mellitus	White	5.6	0.0	6.5	35.5	7.1	52.8	26.8	69.2	44.0	53.5	11.0	0.0	16.5	0.0	16.0	33.3	45.7	14.7
	Black	47.0	62.1	20.1	5.3	19.5	35.0	37.5	25.5	0.0	0.0	35.5	0.0	0.0	0.0	0.0	5.5	25.1	6.3
	Male	0.0	20.2	4.2	35.9	26.7	46.8	45.1	18.7	23.0	7.5	0.0	3.1	9.3	0.0	16.0	36.0	23.1	8.5
	Female	52.6	41.9	22.4	4.9	0.0	41.0	19.2	76.0	21.0	46.1	46.5	0.0	7.2	0.0	0.0	2.8	47.6	12.5
	White male	0.0	0.0	3.8	35.5	7.1	27.3	7.6	18.7	23.0	7.5	0.0	0.0	9.3	0.0	16.0	30.5	8.6	2.6
	White female	5.6	0.0	2.7	0.0	0.0	25.5	19.2	50.5	21.0	46.1	11.0	0.0	7.2	0.0	0.0	2.8	37.1	12.1
	Black male	0.0	20.2	0.4	0.4	19.5	19.5	37.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	14.5	5.9
	Black female	47.0	41.9	19.7	4.9	0.0	15.5	0.0	25.5	0.0	0.0	35.5	0.0	0.0	0.0	0.0	0.0	10.6	0.4
Homicide	White	107.4	23.2	38.8	16.7	29.5	35.5	69.7	29.2	15.0	5.1	25.5	18.4	88.3	1.0	55.5	79.6	7.8	15.6
	Black	210.2	363.6	106.0	207.6	203.1	45.5	106.0	97.0	20.9	0.0	0.0	31.1	13.7	0.0	81.0	0.0	144.7	2.0
	Male	298.9	295.1	132.2	215.3	187.6	0.0	175.7	115.2	15.0	0.0	25.5	18.4	102.0	1.0	101.0	79.6	112.8	0.0
	Female	18.7	91.7	12.6	9.0	45.0	81.0	0.0	11.0	20.9	5.1	0.0	31.1	0.0	0.0	35.5	0.0	39.7	17.7
	White male	107.3	18.8	38.5	9.6	0.0	0.0	69.7	29.2	15.0	0.0	25.5	18.4	88.3	1.0	55.5	79.6	0.0	0.0
	White female	0.1	4.3	0.3	7.1	29.5	35.5	0.0	0.0	0.0	5.1	0.0	0.0	0.0	0.0	0.0	0.0	7.8	15.6
	Black male	191.6	276.3	93.7	205.8	187.6	0.0	106.0	86.0	0.0	0.0	0.0	0.0	13.7	0.0	45.5	0.0	112.8	0.0
	Black female	18.6	87.4	12.3	1.8	15.5	45.5	0.0	11.0	20.9	0.0	0.0	31.1	0.0	0.0	35.5	0.0	31.9	2.0
Chronic Liver Disease and Cirrhosis	White	37.3	59.3	5.3	93.8	53.1	0.0	4.5	52.0	0.0	25.5	5.5	25.6	34.0	22.4	15.5	64.2	15.5	0.4
	Black	11.7	38.0	0.5	0.5	11.4	11.4	83.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	32.7	78.5	5.8	94.3	53.1	0.0	2.2	28.8	0.0	0.0	5.5	0.0	25.5	5.5	0.0	25.7	0.0	0.0
	Female	16.3	18.8	0.0	0.0	11.4	11.4	86.1	23.2	0.0	25.5	0.0	25.6	8.5	16.9	15.5	38.5	15.5	0.4
	White male	20.9	40.5	5.3	93.8	53.1	0.0	2.2	28.8	0.0	0.0	5.5	0.0	25.5	5.5	0.0	25.7	0.0	0.0
	White female	16.3	18.8	0.0	0.0	0.0	0.0	2.3	23.2	0.0	25.5	0.0	25.6	8.5	16.9	15.5	38.5	15.5	0.4
	Black male	11.7	38.0	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	0.0	0.0	0.0	0.0	11.4	11.4	83.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Suicide	White	46.9	4.3	50.3	39.2	14.0	112.0	50.1	7.9	15.0	77.4	42.8	28.2	107.7	106.5	101.0	51.8	57.4	34.1
	Black	33.2	0.0	12.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	16.7	0.0	0.0	0.0	14.9	0.0
	Male	39.6	4.3	35.3	35.9	14.0	112.0	50.1	7.9	15.0	41.9	42.8	48.1	107.7	61.0	101.0	22.4	60.5	34.1
	Female	40.5	0.0	27.2	3.3	0.0	0.0	0.0	0.0	0.0	35.5	0.0	0.0	16.7	45.5	0.0	29.4	11.7	0.0
	White male	6.4	4.3	23.0	35.9	14.0	112.0	50.1	7.9	15.0	41.9	42.8	28.2	107.7	61.0	101.0	22.4	45.6	34.1
	White female	40.5	0.0	27.2	3.3	0.0	0.0	0.0	0.0	0.0	35.5	0.0	0.0	0.0	45.5	0.0	29.4	11.7	0.0
	Black male	33.2	0.0	12.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	14.9	0.0
	Black female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	16.7	0.0	0.0	0.0	0.0	0.0

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Data Table 77. Years of Potential Life Lost by Council District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Council District																	
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	unknown
Chronic Obstructive Pulmonary Disease or Chronic Lower Respiratory Disease	White	16.6	3.1	24.4	45.9	9.6	7.9	6.1	16.1	36.8	56.3	11.8	6.7	11.6	9.1	9.0	7.4	5.5	11.0
	Black	5.5	36.8	17.1	0.0	0.0	3.9	2.7	64.8	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.0	0.0	0.0
	Male	11.9	0.2	24.9	29.1	9.6	4.6	1.9	10.2	24.4	12.2	9.7	3.2	9.6	9.1	1.2	0.5	5.5	5.5
	Female	10.3	39.8	16.6	16.9	0.0	7.2	6.9	70.8	12.4	44.2	2.1	3.5	2.0	0.0	9.5	6.9	0.0	5.5
	White male	6.4	0.0	7.8	29.1	9.6	0.7	1.9	10.2	24.4	12.2	9.7	3.2	9.6	9.1	1.2	0.5	5.5	5.5
	White female	10.3	3.1	16.6	16.9	0.0	7.2	4.2	6.0	12.4	44.2	2.1	3.5	2.0	0.0	7.9	6.9	0.0	5.5
	Black male	5.5	0.2	17.1	0.0	0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	0.0	36.7	0.0	0.0	0.0	0.0	2.7	64.8	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.0	0.0	0.0
Accidents	White	48.8	5.9	79.7	55.6	203.1	91.2	42.6	151.4	146.1	86.7	95.3	159.1	333.4	51.9	94.1	96.0	151.0	132.0
	Black	231.3	185.3	123.7	0.0	0.0	0.0	48.5	21.4	16.1	0.0	31.6	28.6	48.8	26.4	12.2	0.0	0.0	45.5
	Male	257.8	72.4	191.5	40.8	149.8	43.7	81.6	201.4	178.7	56.2	126.9	163.8	266.8	51.8	30.4	37.5	151.0	162.0
	Female	22.4	118.8	11.8	14.9	53.3	47.5	9.6	22.1	10.2	30.5	0.0	47.5	115.4	26.5	75.8	58.5	0.0	0.0
	White male	48.8	5.9	78.7	40.8	149.8	43.7	33.0	129.3	135.9	56.2	95.3	111.6	217.9	25.4	18.3	37.5	151.0	116.5
	White female	0.0	0.0	1.0	14.9	53.3	47.5	9.6	22.1	10.2	30.5	0.0	47.5	115.4	26.5	75.8	58.5	0.0	15.5
	Black male	209.0	66.5	112.8	0.0	0.0	0.0	48.5	21.4	16.1	0.0	31.6	28.6	48.8	26.4	12.2	0.0	0.0	45.5
	Black female	22.4	118.8	10.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Diabetes Mellitus	White	24.7	0.0	12.9	89.9	19.6	24.0	1.8	9.7	23.0	6.9	13.8	34.6	53.0	8.2	1.0	8.7	0.0	25.5
	Black	16.1	17.0	36.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	4.1	1.1	0.0	0.0	0.0	0.0
	Male	19.8	11.0	38.4	64.4	4.1	24.0	0.0	4.2	17.5	6.2	15.9	0.3	4.1	1.1	0.0	0.5	0.0	0.0
	Female	21.0	6.0	11.0	25.5	15.5	0.0	1.8	5.5	5.4	1.0	0.0	34.6	53.0	8.2	1.0	8.2	0.0	25.5
	White male	3.7	0.0	12.9	64.4	4.1	24.0	0.0	4.2	17.5	5.9	13.8	0.3	4.1	1.1	0.0	0.5	0.0	0.0
	White female	21.0	0.0	0.0	25.5	15.5	0.0	1.8	5.5	5.4	1.0	0.0	34.3	49.0	7.1	1.0	8.2	0.0	25.5
	Black male	16.1	11.0	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	0.0	6.0	11.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	4.1	1.1	0.0	0.0	0.0	0.0
Homicide	White	0.0	0.4	4.5	15.5	0.0	11.0	12.1	106.7	52.3	10.5	0.0	52.3	72.3	0.0	4.5	0.0	0.0	35.5
	Black	327.4	331.1	266.6	0.0	0.0	18.1	12.5	0.0	29.3	12.0	70.5	66.4	71.0	9.1	4.6	0.0	0.0	0.0
	Male	271.9	331.5	237.6	15.5	0.0	18.1	0.0	75.1	81.6	19.2	49.4	118.7	143.4	9.1	0.6	0.0	0.0	0.0
	Female	55.5	0.0	79.0	0.0	0.0	11.0	24.6	31.6	6.4	42.5	21.1	0.0	0.0	0.0	8.5	0.0	0.0	0.0
	White male	0.0	0.4	0.0	15.5	0.0	0.0	0.0	75.1	52.3	10.5	0.0	52.3	72.3	0.0	0.6	0.0	0.0	0.0
	White female	0.0	0.0	4.5	0.0	0.0	11.0	12.1	31.6	0.0	0.0	0.0	0.0	0.0	0.0	3.9	0.0	0.0	35.5
	Black male	271.9	331.1	192.1	0.0	0.0	18.1	0.0	0.0	29.3	8.6	49.4	66.4	71.0	9.1	0.0	0.0	0.0	0.0
	Black female	55.5	0.0	74.5	0.0	0.0	0.0	12.5	0.0	0.0	3.3	21.1	0.0	0.0	0.0	4.6	0.0	0.0	0.0
Chronic Liver Disease and Cirrhosis	White	2.0	0.8	0.4	5.5	0.0	5.1	1.2	23.4	12.8	0.0	4.9	0.0	21.0	0.0	5.0	0.0	0.0	15.5
	Black	40.3	65.3	42.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	5.4	2.6	34.2	5.5	0.0	5.1	0.0	18.5	12.8	0.0	4.9	0.0	15.5	0.0	0.1	0.0	0.0	15.5
	Female	37.0	63.6	8.3	0.0	0.0	0.0	1.2	4.9	0.0	0.0	0.0	0.0	5.5	0.0	5.0	0.0	0.0	0.0
	White male	0.0	0.5	0.4	5.5	0.0	5.1	0.0	18.5	12.8	0.0	4.9	0.0	15.5	0.0	0.1	0.0	0.0	15.5
	White female	2.0	0.4	0.0	0.0	0.0	0.0	1.2	4.9	0.0	0.0	0.0	0.0	5.5	0.0	5.0	0.0	0.0	0.0
	Black male	5.4	2.1	33.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	35.0	63.2	8.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Suicide	White	27.3	41.0	4.1	64.7	45.5	46.0	71.5	83.0	66.5	58.3	13.8	69.2	105.1	60.8	35.6	35.6	21.7	132.0
	Black	41.2	91.0	16.1	0.0	0.0	39.4	7.6	0.0	28.3	10.5	0.0	0.0	0.0	0.0	2.8	0.0	0.0	0.0
	Male	33.0	96.5	20.2	64.7	45.5	60.4	41.3	60.7	40.4	60.4	27.3	24.7	35.7	9.1	22.5	35.6	21.7	132.0
	Female	35.5	35.5	0.0	0.0	0.0	25.0	37.9	22.3	54.4	10.5	0.0	44.6	69.4	51.7	15.9	0.0	0.0	0.0
	White male	27.3	41.0	4.1	64.7	45.5	20.9	33.7	60.7	40.4	58.3	13.8	24.7	35.7	9.1	19.7	35.6	21.7	132.0
	White female	0.0	0.0	0.0	0.0	0.0	25.0	37.9	22.3	26.1	0.0	0.0	44.6	69.4	51.7	15.9	0.0	0.0	0.0
	Black male	5.7	55.5	16.1	0.0	0.0	39.4	7.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.8	0.0	0.0	0.0
	Black female	35.5	35.5	0.0	0.0	0.0	0.0	0.0	0.0	28.3	10.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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Data Table 77. Years of Potential Life Lost by Council District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Council District																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Hypertension	White	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black	2.5	27.4	0.5	0.5	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	0.0	24.5	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Female	2.5	2.9	0.0	0.0	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black male	0.0	24.5	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	2.5	2.9	0.0	0.0	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Congenital Anomalies	White	0.0	0.0	0.0	67.5	74.5	0.0	0.0	0.0	0.0	0.0	0.0	41.7	0.0	35.5	0.0	0.0	0.0	0.0
	Black	25.5	42.1	0.0	20.9	41.0	61.0	29.8	44.7	0.0	0.0	0.0	53.6	17.9	3.0	0.0	0.0	28.7	0.0
	Male	25.5	29.4	0.0	67.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	53.6	17.9	38.5	0.0	0.0	0.0	0.0
	Female	0.0	12.7	0.0	20.9	115.5	61.0	29.8	44.7	0.0	0.0	0.0	41.7	0.0	0.0	0.0	0.0	28.7	0.0
	White male	0.0	0.0	0.0	67.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	35.5	0.0	0.0	0.0	0.0
	White female	0.0	0.0	0.0	0.0	74.5	0.0	0.0	0.0	0.0	0.0	0.0	41.7	0.0	0.0	0.0	0.0	0.0	0.0
	Black male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	53.6	17.9	3.0	0.0	0.0	0.0	0.0
	Black female	0.0	12.7	0.0	20.9	41.0	61.0	29.8	44.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	28.7	0.0
Alzheimer's Disease	White	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black	4.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Female	4.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	4.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HIV/AIDS	White	45.5	34.1	2.8	0.7	0.0	61.0	77.9	48.6	33.4	0.0	35.5	0.0	0.0	0.0	0.0	24.0	18.7	6.0
	Black	124.6	129.9	1.4	16.9	96.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	22.4	0.0
	Male	153.8	145.2	4.3	17.6	61.0	35.5	77.9	48.6	33.4	0.0	35.5	0.0	0.0	0.0	0.0	0.8	22.4	6.0
	Female	16.3	18.8	0.0	0.0	35.5	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	23.2	18.7	0.0
	White male	45.5	34.1	2.8	0.7	0.0	35.5	77.9	48.6	33.4	0.0	35.5	0.0	0.0	0.0	0.0	0.8	0.0	6.0
	White female	0.0	0.0	0.0	0.0	0.0	25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	23.2	18.7	0.0
	Black male	108.3	111.1	1.4	16.9	61.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	22.4	0.0
	Black female	16.3	18.8	0.0	0.0	35.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Prenatal Conditions	White	1.5	0.0	4.5	0.0	0.0	0.0	0.0	0.0	0.0	217.5	74.5	95.4	66.3	77.5	0.0	85.7	0.0	0.0
	Black	88.7	111.0	41.7	63.3	74.5	74.5	0.0	23.1	118.5	0.0	0.0	41.7	0.0	0.0	0.0	0.0	74.5	0.0
	Male	35.8	111.0	18.6	63.3	74.5	74.5	0.0	0.0	74.5	143.0	0.0	53.6	17.9	3.0	0.0	59.6	74.5	0.0
	Female	54.4	0.0	27.6	0.0	0.0	0.0	0.0	23.1	44.0	74.5	74.5	83.4	48.4	74.5	0.0	26.1	0.0	0.0
	White male	1.5	0.0	4.5	0.0	0.0	0.0	0.0	0.0	0.0	143.0	0.0	53.6	17.9	3.0	0.0	59.6	0.0	0.0
	White female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	74.5	74.5	41.7	48.4	74.5	0.0	26.1	0.0	0.0
	Black male	34.3	111.0	14.2	63.3	74.5	74.5	0.0	0.0	74.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	74.5	0.0
	Black female	54.4	0.0	27.6	0.0	0.0	0.0	0.0	23.1	44.0	0.0	0.0	41.7	0.0	0.0	0.0	0.0	0.0	0.0
Heart Disease	White	268.2	121.4	199.6	237.0	180.7	317.9	218.6	281.0	499.6	331.4	196.7	178.8	139.1	256.8	129.5	183.3	72.9	51.0
	Black	172.2	289.0	120.7	203.0	177.8	103.2	213.0	15.8	28.7	0.0	9.7	89.9	17.0	28.3	1.0	21.6	97.5	11.7
	Male	354.6	273.2	231.6	311.8	215.3	250.0	339.9	204.0	308.8	229.9	145.5	197.0	114.7	261.3	64.5	181.1	115.6	29.5
	Female	85.8	137.3	88.8	128.2	143.2	171.0	91.7	92.9	280.5	101.5	45.9	75.7	46.4	39.1	66.0	25.7	54.8	33.2
	White male	196.6	90.4	116.9	130.6	78.2	197.5	183.5	188.1	244.6	229.9	145.5	144.5	104.8	234.1	64.5	165.6	38.9	26.5
	White female	71.7	31.1	82.7	106.4	102.5	120.3	35.1	92.9	255.0	101.5	36.2	34.3	34.3	37.7	65.0	17.7	34.1	24.5
	Black male	158.0	182.8	114.7	181.1	137.0	52.5	156.4	15.8	28.7	0.0	0.0	48.5	8.5	26.9	0.0	15.5	76.7	2.9
	Black female	14.1	106.2	6.1	21.9	40.7	50.7	56.6	0.0	0.0	0.0	9.7	41.4	8.5	1.4	1.0	6.1	20.8	8.8
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Data Table 77. Years of Potential Life Lost by Council District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Council District																	
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	unknown
Hypertension	White	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black	32.4	13.5	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	32.4	13.4	1.7	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White male	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black male	32.4	13.4	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Congenital Anomalies	White	0.0	55.5	11.9	0.0	0.0	137.1	1.2	21.6	0.0	4.5	28.3	0.0	0.0	46.3	39.5	0.0	0.0	0.0
	Black	36.5	158.5	191.4	0.0	0.0	0.0	0.0	32.4	0.0	0.0	0.0	35.1	55.5	0.0	0.0	0.0	0.0	0.0
	Male	17.1	139.5	48.4	0.0	0.0	0.0	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.4	39.5	0.0	0.0	0.0
	Female	19.3	74.5	154.9	0.0	0.0	137.1	0.0	54.0	10.4	68.5	28.3	35.1	55.5	45.9	0.0	0.0	0.0	0.0
	White male	0.0	55.5	0.0	0.0	0.0	0.0	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.4	39.5	0.0	0.0	0.0
	White female	0.0	0.0	11.9	0.0	0.0	137.1	0.0	21.6	0.0	4.5	28.3	0.0	0.0	45.9	0.0	0.0	0.0	0.0
	Black male	17.1	138.9	48.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	19.3	74.5	143.0	0.0	0.0	0.0	0.0	32.4	0.0	0.0	0.0	35.1	55.5	0.0	0.0	0.0	0.0	0.0
Alzheimer's Disease	White	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White male	0.0	0.0	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black male	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HIV/AIDS	White	3.6	0.0	51.8	23.2	23.8	0.0	0.0	24.5	0.0	0.0	0.0	3.5	2.0	0.0	0.3	13.8	33.4	0.0
	Black	212.8	305.4	163.5	71.0	0.0	18.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	194.8	259.5	182.3	94.2	23.8	18.1	0.0	24.5	0.0	0.0	0.0	3.5	2.0	0.0	0.3	13.8	33.4	0.0
	Female	21.6	45.9	33.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	White male	0.0	0.0	51.8	23.2	23.8	0.0	0.0	24.5	0.0	0.0	0.0	3.5	2.0	0.0	0.3	13.8	33.4	0.0
	White female	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black male	194.8	259.5	130.5	71.0	0.0	18.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	18.0	45.9	33.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Prenatal Conditions	White	0.0	0.0	0.0	0.0	0.0	82.0	67.1	14.9	0.0	4.5	28.3	0.0	74.5	0.0	0.0	0.0	0.0	0.0
	Black	0.0	149.7	74.5	0.0	0.0	0.0	0.0	71.5	0.0	4.5	28.3	77.5	74.5	0.0	0.0	0.0	0.0	149.0
	Male	0.0	149.7	0.0	0.0	74.5	41.0	33.5	14.9	0.0	0.0	0.0	46.9	102.1	0.0	0.0	0.0	0.0	74.5
	Female	0.0	0.0	74.5	0.0	0.0	41.0	33.5	71.5	0.0	8.9	56.6	77.5	74.5	0.0	0.0	0.0	0.0	74.5
	White male	0.0	0.0	0.0	0.0	0.0	41.0	33.5	14.9	0.0	0.0	0.0	0.0	74.5	0.0	0.0	0.0	0.0	0.0
	White female	0.0	0.0	0.0	0.0	0.0	41.0	33.5	0.0	0.0	4.5	28.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black male	0.0	149.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	74.5
	Black female	0.0	0.0	74.5	0.0	0.0	0.0	0.0	71.5	0.0	4.5	28.3	77.5	74.5	0.0	0.0	0.0	0.0	74.5
Heart Disease	White	126.4	35.6	100.8	191.7	179.8	107.7	44.2	163.9	166.4	83.7	70.2	167.8	240.9	140.1	106.2	96.4	102.5	135.0
	Black	244.0	431.4	193.9	67.9	17.1	22.2	4.6	2.9	14.0	72.1	15.6	23.3	40.1	3.1	1.0	0.0	13.9	31.0
	Male	183.2	307.7	182.8	186.7	108.0	76.7	30.5	115.2	113.6	76.9	64.9	162.1	184.2	92.8	88.3	58.7	46.4	155.0
	Female	187.1	159.3	111.9	79.2	88.9	72.4	18.3	51.6	69.0	92.3	20.9	29.0	96.8	50.4	19.0	37.7	70.0	11.0
	White male	94.0	29.7	68.9	118.8	108.0	72.5	27.8	115.2	108.6	43.9	49.3	139.7	155.6	92.8	87.3	58.7	40.9	124.0
	White female	32.4	5.9	31.9	72.9	71.8	35.2	16.4	48.7	57.8	39.8	20.9	28.1	85.4	47.3	19.0	37.7	61.6	11.0
	Black male	89.3	277.9	113.9	67.9	0.0	4.1	2.7	0.0	5.0	33.0	15.6	22.4	28.6	0.0	1.0	0.0	5.5	31.0
	Black female	154.7	153.5	80.0	0.0	17.1	18.1	1.9	2.9	9.0	39.1	0.0	0.9	11.5	3.1	0.0	0.0	8.4	0.0

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Data Table 77. Years of Potential Life Lost by Council District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Council District																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Stroke	White	30.8	4.3	30.6	29.0	15.8	33.2	8.0	6.4	69.1	30.3	5.5	4.0	9.5	21.2	6.0	54.0	0.0	0.0
	Black	27.9	77.5	9.5	36.6	3.0	0.0	0.0	71.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	28.8	0.0
	Male	40.8	40.9	26.2	34.1	1.8	17.3	2.0	6.4	59.4	0.0	5.5	4.0	6.0	15.7	5.5	20.4	7.3	0.0
	Female	18.0	40.9	13.9	31.5	17.1	31.5	6.1	71.0	9.7	30.3	0.0	0.0	3.6	21.0	0.5	33.6	19.5	0.0
	White male	28.5	0.0	23.0	20.7	1.8	17.3	2.0	6.4	59.4	0.0	5.5	4.0	6.0	0.2	5.5	20.4	0.0	0.0
	White female	4.3	4.3	7.5	8.3	14.0	16.0	6.1	0.0	9.7	30.3	0.0	0.0	3.6	21.0	0.5	33.6	0.0	0.0
	Black male	14.3	40.9	3.1	13.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.3	0.0
	Black female	13.7	36.5	6.3	23.2	3.0	0.0	0.0	71.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	19.5	0.0
Cancer	White	241.7	64.0	177.6	287.7	106.3	329.9	140.1	130.4	196.8	327.0	304.5	252.8	190.6	252.1	328.1	216.5	56.3	30.6
	Black	195.5	234.2	74.3	142.6	200.3	94.3	109.3	36.4	61.0	5.1	25.6	50.6	13.7	0.0	31.0	7.2	195.6	54.3
	Male	254.0	186.9	124.4	232.6	180.9	266.2	220.0	81.9	121.5	236.2	222.6	208.6	118.7	123.0	176.6	148.1	100.2	16.6
	Female	174.8	111.2	135.5	197.6	125.7	158.0	96.9	82.0	139.5	95.9	107.5	141.8	96.5	130.9	182.5	75.5	151.7	54.2
	White male	169.9	17.8	78.8	144.5	46.7	172.0	94.1	61.7	92.8	236.2	199.1	150.2	118.7	123.0	145.6	146.4	24.9	5.3
	White female	71.9	46.2	98.8	143.2	59.7	158.0	45.9	68.8	104.0	90.8	105.4	102.6	71.9	129.1	182.5	70.0	31.4	25.3
	Black male	92.5	169.1	37.5	88.2	134.3	94.3	58.3	23.2	25.5	0.0	23.5	44.1	0.0	0.0	31.0	1.7	75.3	11.4
	Black female	103.0	65.0	36.8	54.5	66.0	0.0	51.0	13.2	35.5	5.1	2.1	6.5	13.7	0.0	0.0	5.5	120.3	28.9
Pneumonia & Influenza	White	18.6	16.8	24.2	3.4	6.1	15.5	11.9	74.9	9.1	0.0	20.5	0.0	5.2	6.0	5.5	6.3	5.1	0.0
	Black	48.0	73.8	2.3	15.9	81.5	35.5	3.2	32.3	5.5	0.0	0.0	0.0	0.0	15.5	0.0	0.0	14.5	0.0
	Male	64.1	81.6	25.0	9.3	88.1	35.5	8.7	37.8	5.5	0.0	15.0	0.0	1.7	16.0	0.0	4.4	8.5	6.8
	Female	2.5	9.0	1.6	9.9	35.0	15.5	3.2	37.1	9.1	0.0	5.5	0.0	3.6	5.5	5.5	1.9	14.5	0.0
	White male	18.6	16.8	22.7	3.4	6.1	0.0	8.7	37.8	0.0	0.0	15.0	0.0	1.7	0.5	0.0	4.4	5.1	0.0
	White female	0.0	0.0	1.6	0.0	0.0	15.5	3.2	37.1	9.1	0.0	5.5	0.0	3.6	5.5	5.5	1.9	0.0	0.0
	Black male	45.5	64.8	2.3	5.9	82.0	35.5	0.0	0.0	5.5	0.0	0.0	0.0	0.0	15.5	0.0	0.0	0.0	0.0
	Black female	2.5	9.0	0.0	9.9	35.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	14.5	0.0
Continued on the next page																			

Data Table 77. Years of Potential Life Lost by Council District, Nashville, TN, 1998

Cause of Death	Race/Gender Group	Council District																	
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	unknown
Stroke	White	13.9	3.6	17.9	23.6	30.3	19.5	19.1	13.9	24.3	2.9	73.9	36.5	32.4	23.5	18.0	29.4	7.3	21.0
	Black	63.8	86.6	34.8	2.8	0.0	0.0	2.7	0.0	3.6	21.9	0.0	16.1	9.4	0.0	1.0	0.0	0.0	0.0
	Male	27.4	81.4	15.2	15.8	3.7	3.0	6.3	5.2	13.2	24.9	13.8	32.1	18.9	8.6	11.1	2.1	7.3	15.5
	Female	50.3	8.8	40.2	13.4	26.6	16.5	15.4	8.7	14.7	0.0	60.1	20.5	22.9	14.9	7.9	27.3	0.0	5.5
	White male	11.9	3.6	12.5	13.0	3.7	3.0	3.6	5.2	9.6	2.9	13.8	32.1	18.9	8.6	10.1	2.1	7.3	15.5
	White female	2.0	0.0	5.4	10.6	26.6	16.5	15.4	8.7	14.7	0.0	60.1	4.4	13.5	14.9	7.9	27.3	0.0	5.5
	Black male	15.5	77.8	0.0	0.0	0.0	0.0	2.7	0.0	3.6	21.9	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
	Black female	48.3	8.8	34.8	2.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	16.1	9.4	0.0	0.0	0.0	0.0	0.0
Cancer	White	75.8	76.1	117.7	231.5	251.9	176.4	168.6	205.6	230.0	152.5	162.0	200.6	278.5	251.5	299.2	228.7	228.4	139.5
	Black	304.5	384.7	219.0	9.4	0.0	14.7	2.5	73.6	39.9	34.2	69.5	19.2	67.9	8.2	0.6	0.0	5.5	25.5
	Male	225.4	200.0	130.6	133.2	130.7	77.0	46.9	191.3	121.2	86.6	176.7	169.4	193.6	129.3	149.8	93.0	103.3	52.0
	Female	167.5	266.6	227.3	113.2	121.2	114.1	124.1	88.0	148.7	101.7	64.5	60.2	158.5	130.4	149.9	135.7	130.6	113.0
	White male	28.0	51.2	45.8	122.2	130.7	77.0	46.9	138.0	116.1	81.7	104.5	157.2	157.5	121.1	149.3	93.0	103.3	52.0
	White female	47.9	24.9	71.9	109.3	121.2	99.5	121.7	67.7	113.9	70.8	57.6	43.5	120.9	130.4	149.9	135.7	125.1	87.5
	Black male	177.8	143.0	84.7	5.5	0.0	0.0	0.0	53.3	5.1	3.3	62.5	2.5	30.3	8.2	0.6	0.0	0.0	0.0
	Black female	119.6	241.7	155.4	3.9	0.0	14.7	2.5	20.3	34.8	30.9	7.0	16.7	37.5	0.0	0.0	0.0	5.5	25.5
Pneumonia & Influenza	White	11.9	3.6	12.5	8.7	19.1	19.4	7.6	8.5	2.8	1.0	0.0	11.5	2.0	0.0	2.8	2.3	0.0	74.5
	Black	11.8	3.5	2.3	0.0	0.0	0.0	0.0	0.0	1.2	0.0	9.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Male	21.7	7.0	7.3	0.0	0.0	16.1	12.9	1.1	4.0	1.0	9.8	0.0	0.0	0.0	2.8	0.0	0.0	74.5
	Female	2.0	0.1	7.6	8.7	19.1	3.3	0.0	7.4	0.0	0.0	0.0	11.5	2.0	0.0	0.0	2.3	0.0	0.0
	White male	11.9	3.6	4.9	0.0	0.0	16.1	7.6	1.1	2.8	1.0	0.0	0.0	0.0	0.0	2.8	0.0	0.0	74.5
	White female	0.0	0.0	7.6	8.7	19.1	3.3	0.0	7.4	0.0	0.0	0.0	11.5	2.0	0.0	0.0	2.3	0.0	0.0
	Black male	9.8	3.4	2.3	0.0	0.0	0.0	0.0	0.0	1.2	0.0	9.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Black female	2.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Data Table 78. Responses to BRFSS Questions about Influenza and Pneumococcal Vaccinations, Nashville, TN, 1998

Question	Response	Total	Gender		Race			Marital Status		Age Group						Highest Level of Education			
			Men	Women	White	Black	Other Races	Married	Single	18-24	25-34	35-44	45-54	55-64	65+	< HS Diploma	HS Diploma	Some College	College Degree
1998																			
During the past 12 months, have you had a flu shot?		N=3230	N*=1488	N*=1742	N*=2447	N*=722	N*=61	N*=1499	N*=1724	N*=438	N*=702	N*=726	N*=549	N*=337	N*=478	N*=369	N*=983	N*=843	N*=1035
	Yes	34.8%	34.5%	35.1%	37.2%	26.7%	34.1%	37.0%	32.9%	23.0%	22.2%	26.6%	38.2%	43.2%	66.8%	33.8%	35.5%	33.0%	35.9%
	No	64.3%	64.3%	64.3%	61.9%	72.6%	63.2%	62.4%	66.2%	75.8%	77.0%	72.6%	61.3%	56.0%	31.9%	62.9%	63.9%	66.4%	63.5%
	Don't know	0.3%	0.4%	0.2%	0.3%	0.1%	0.9%	0.3%	0.3%	0.0%	0.8%	0.3%	0.2%	0.0%	0.1%	0.5%	0.1%	0.2%	0.4%
	Refused	0.6%	0.8%	0.5%	0.6%	0.6%	1.9%	0.4%	0.7%	1.3%	0.1%	0.5%	0.4%	0.8%	1.2%	2.8%	0.5%	0.4%	0.2%
Have you ever had a pneumonia vaccination?		N=3230	N*=1488	N*=1742	N*=2447	N*=722	N*=61	N*=1499	N*=1724	N*=438	N*=702	N*=726	N*=549	N*=337	N*=478	N*=369	N*=983	N*=843	N*=1035
	Yes	16.9%	16.1%	17.5%	17.0%	16.9%	10.6%	16.2%	17.5%	10.0%	10.4%	5.7%	13.2%	22.7%	49.9%	21.8%	18.0%	17.5%	13.5%
	No	79.7%	79.8%	79.5%	79.4%	80.1%	84.5%	80.6%	78.9%	85.5%	84.7%	92.1%	84.7%	73.8%	46.4%	71.8%	79.9%	79.9%	82.1%
	Don't know	2.9%	3.3%	2.5%	3.0%	2.4%	3.1%	2.8%	2.9%	3.3%	4.9%	1.8%	1.8%	2.7%	2.5%	3.6%	1.7%	2.3%	4.2%
	Refused	0.6%	0.8%	0.5%	0.6%	0.6%	1.9%	0.4%	0.7%	1.3%	0.1%	0.5%	0.4%	0.8%	1.2%	2.8%	0.5%	0.4%	0.2%

Question	Response	Planning Districts															
		Joelton	Belshire/ Union Hill	Bordeaux/ Whites Creek	Madison/ Goodletts- ville	East Nashville/ Inglewood	Bellevue	The Nations/ Sylvan Park	Belle Meade/ West Meade	North Nashville	Downtown	West End/ Vanderbilt	Forest Hills/ Oak Hill	Berry Hill/ Woodbine	Tusculum/ Crieve Hall	Priest Lake/ Antioch	Donelson/ Hermitage
1998																	
During the past 12 months, have you had a flu shot?		N*=182	N*=206	N*=199	N*=199	N*=193	N*=208	N*=202	N*=205	N*=179	N*=187	N*=206	N*=194	N*=206	N*=216	N*=222	N*=227
	Yes	35.0%	37.2%	35.6%	34.5%	32.1%	40.4%	40.9%	39.2%	30.7%	23.3%	40.1%	38.1%	36.2%	28.7%	29.5%	34.3%
	No	65.0%	62.3%	63.3%	65.2%	66.0%	57.1%	57.4%	60.5%	67.1%	76.6%	58.2%	61.6%	62.6%	71.3%	70.3%	65.3%
	Don't know	0.0%	0.5%	0.0%	0.0%	0.3%	0.6%	0.7%	0.0%	0.0%	0.0%	1.6%	0.0%	0.6%	0.0%	0.0%	0.0%
	Refused	0.0%	0.0%	1.1%	0.4%	1.5%	1.9%	1.1%	0.4%	2.2%	0.1%	0.0%	0.3%	0.6%	0.0%	0.2%	0.4%
Have you ever had a pneumonia vaccination?		N*=182	N*=206	N*=199	N*=199	N*=193	N*=208	N*=202	N*=205	N*=179	N*=187	N*=206	N*=194	N*=206	N*=216	N*=222	N*=227
	Yes	17.6%	16.7%	14.8%	14.9%	14.0%	17.1%	17.9%	20.5%	14.6%	16.1%	22.7%	19.7%	16.6%	16.4%	18.3%	12.0%
	No	77.3%	82.2%	82.1%	83.1%	82.7%	77.9%	77.4%	75.0%	80.1%	81.3%	73.5%	75.7%	79.2%	81.4%	80.4%	84.5%
	Don't know	5.0%	1.1%	2.0%	1.7%	1.8%	3.1%	3.6%	4.1%	3.2%	2.5%	3.8%	4.3%	3.6%	2.3%	1.1%	3.1%
	Refused	0.0%	0.0%	1.1%	0.4%	1.5%	1.9%	1.1%	0.4%	2.2%	0.1%	0.0%	0.3%	0.6%	0.0%	0.2%	0.4%

*Numbers have been adjusted to match the gender-race-age distribution of Nashville, TN for 1998.

Data Table 79. Influenza Vaccination Rates by ZIP Code and Subgroup*, Nashville, TN, 2000

ZIP Code	MALE			FEMALE			WHITE			BLACK			OTHER		
	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated
37011	18	4	22.2%	19	6	31.6%	29	10	34.5%	6	0	0.0%	2	0	0.0%
37013	599	233	38.9%	985	363	36.9%	1,388	558	40.2%	145	26	17.9%	51	12	23.5%
37015	484	197	40.7%	756	372	49.2%	1,193	554	46.4%	39	12	30.8%	8	3	37.5%
37027	1,043	441	42.3%	1,408	562	39.9%	2,368	978	41.3%	51	13	25.5%	32	12	37.5%
37064	1,062	441	41.5%	1,700	687	40.4%	2,388	1,058	44.3%	349	63	18.1%	25	7	28.0%
37070	49	11	22.4%	58	14	24.1%	104	24	23.1%	3	1	33.3%	.	.	.
37072	883	355	40.2%	1,257	526	41.8%	2,069	855	41.3%	51	20	39.2%	20	6	30.0%
37076	816	370	45.3%	1,351	640	47.4%	2,095	988	47.2%	47	15	31.9%	25	7	28.0%
37080	292	83	28.4%	396	133	33.6%	678	213	31.4%	9	3	33.3%	1	0	0.0%
37086	292	109	37.3%	408	180	44.1%	634	277	43.7%	56	12	21.4%	10	0	0.0%
37115	1,133	494	43.6%	2,354	1,103	46.9%	3,272	1,536	46.9%	195	58	29.7%	20	3	15.0%
37116	53	13	24.5%	59	17	28.8%	100	30	30.0%	9	0	0.0%	3	0	0.0%
37122	794	300	37.8%	1,084	405	37.4%	1,775	680	38.3%	89	22	24.7%	14	3	21.4%
37135	132	32	24.2%	147	52	35.4%	255	81	31.8%	24	3	12.5%	.	.	.
37138	720	279	38.8%	1,141	499	43.7%	1,788	758	42.4%	57	17	29.8%	16	3	18.8%
37143	106	34	32.1%	141	57	40.4%	242	90	37.2%	3	0	0.0%	2	1	50.0%
37189	106	29	27.4%	185	46	24.9%	251	70	27.9%	38	4	10.5%	2	1	50.0%
37201	10	2	20.0%	15	5	33.3%	20	7	35.0%	4	0	0.0%	1	0	0.0%
37202	28	5	17.9%	32	7	21.9%	36	11	30.6%	23	1	4.3%	1	0	0.0%
37203	295	67	22.7%	570	162	28.4%	302	102	33.8%	546	124	22.7%	17	3	17.6%
37204	466	159	34.1%	889	324	36.4%	867	375	43.3%	476	107	22.5%	12	1	8.3%
37205	1,394	601	43.1%	2,494	1,085	43.5%	3,807	1,668	43.8%	46	10	21.7%	35	8	22.9%
37206	809	250	30.9%	1,441	447	31.0%	1,650	611	37.0%	587	84	14.3%	13	2	15.4%
37207	988	268	27.1%	1,621	444	27.4%	1,228	446	36.3%	1,362	263	19.3%	19	3	15.8%
37208	561	91	16.2%	1,029	187	18.2%	55	11	20.0%	1,524	265	17.4%	11	2	18.2%
37209	905	330	36.5%	1,562	549	35.1%	1,948	780	40.0%	485	87	17.9%	34	12	35.3%
37210	468	137	29.3%	937	303	32.3%	1,036	391	37.7%	347	48	13.8%	22	1	4.5%
37211	1,626	632	38.9%	2,964	1,133	38.2%	4,293	1,695	39.5%	219	52	23.7%	78	18	23.1%
37212	283	79	27.9%	699	195	27.9%	623	204	32.7%	345	68	19.7%	14	2	14.3%
37213	1	0	0.0%	4	1	25.0%	3	1	33.3%	2	0	0.0%	.	.	.
37214	1,044	403	38.6%	1,688	638	37.8%	2,674	1,030	38.5%	45	9	20.0%	13	2	15.4%
37215	1,125	485	43.1%	1,999	862	43.1%	3,064	1,334	43.5%	29	6	20.7%	31	7	22.6%
37216	813	289	35.5%	1,383	511	36.9%	1,902	743	39.1%	275	51	18.5%	19	6	31.6%
37217	563	213	37.8%	975	345	35.4%	1,399	534	38.2%	122	22	18.0%	17	2	11.8%
37218	594	132	22.2%	1,031	241	23.4%	512	146	28.5%	1,101	226	20.5%	12	1	8.3%
37219	39	12	30.8%	76	17	22.4%	78	27	34.6%	32	0	0.0%	5	2	40.0%
37220	432	194	44.9%	642	280	43.6%	1,064	468	44.0%	3	2	66.7%	7	4	57.1%
37221	857	386	45.0%	1,441	649	45.0%	2,214	1,018	46.0%	54	11	20.4%	30	6	20.0%
37222	22	6	27.3%	37	12	32.4%	51	16	31.4%	8	2	25.0%	.	.	.
37224	21	7	33.3%	20	7	35.0%	28	9	32.1%	13	5	38.5%	.	.	.
37227	6	1	16.7%	4	0	0.0%	6	1	16.7%	3	0	0.0%	1	0	0.0%
37228	62	15	24.2%	139	53	38.1%	48	21	43.8%	150	47	31.3%	3	0	0.0%
37229	9	3	33.3%	7	2	28.6%	13	5	38.5%	3	0	0.0%	.	.	.
37230	.	.	.	6	2	33.3%	6	2	33.3%	.	.	.	.	.	.
37237	2	0	0.0%	.	.	.	2	0	0.0%	.	.	.	.	.	.
37243	1	0	0.0%	.	.	.	.	.	.	1	0	0.0%	.	.	.
TOTAL	22,006	8,192	37.2%	37,154	14,123	38.0%	49,558	20,416	41.2%	8,976	1,759	19.6%	626	140	22.4%

* Race categories based on national Enrollment Data Base (EDB) race code.

Data Table 80. Pneumococcal Vaccination Rates by ZIP Code and Subgroup*, Nashville, TN, 2000

ZIP Code	MALE			FEMALE			WHITE			BLACK			OTHER		
	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated	Number of Beneficiaries	Number of Vaccinated	Percent Vaccinated
37011	14	4	28.6%	18	8	44.4%	25	10	40.0%	5	2	40.0%	2	0	0.0%
37013	552	215	38.9%	915	386	42.2%	1,289	564	43.8%	134	31	23.1%	44	6	13.6%
37015	428	143	33.4%	678	280	41.3%	1,062	413	38.9%	39	10	25.6%	5	0	0.0%
37027	967	441	45.6%	1,320	586	44.4%	2,212	1,001	45.3%	48	14	29.2%	27	12	44.4%
37064	998	356	35.7%	1,608	602	37.4%	2,273	891	39.2%	310	59	19.0%	23	8	34.8%
37070	42	16	38.1%	52	17	32.7%	91	31	34.1%	3	2	66.7%	.	.	.
37072	833	330	39.6%	1,189	512	43.1%	1,954	822	42.1%	48	14	29.2%	20	6	30.0%
37076	751	323	43.0%	1,250	612	49.0%	1,936	912	47.1%	44	16	36.4%	21	7	33.3%
37080	266	90	33.8%	370	156	42.2%	626	245	39.1%	9	1	11.1%	1	0	0.0%
37086	264	84	31.8%	382	156	40.8%	582	228	39.2%	54	11	20.4%	10	1	10.0%
37115	1,065	427	40.1%	2,217	982	44.3%	3,085	1,359	44.1%	178	49	27.5%	19	1	5.3%
37116	46	16	34.8%	57	23	40.4%	91	37	40.7%	9	1	11.1%	3	1	33.3%
37122	720	296	41.1%	997	410	41.1%	1,617	678	41.9%	86	24	27.9%	14	4	28.6%
37135	123	39	31.7%	140	52	37.1%	241	87	36.1%	22	4	18.2%	.	.	.
37138	655	268	40.9%	1,068	496	46.4%	1,654	746	45.1%	55	15	27.3%	14	3	21.4%
37143	97	48	49.5%	135	57	42.2%	227	104	45.8%	3	0	0.0%	2	1	50.0%
37189	96	26	27.1%	175	73	41.7%	233	89	38.2%	36	8	22.2%	2	2	100.0%
37201	10	4	40.0%	14	4	28.6%	20	7	35.0%	3	1	33.3%	1	0	0.0%
37202	27	5	18.5%	31	8	25.8%	35	11	31.4%	22	2	9.1%	1	0	0.0%
37203	274	61	22.3%	551	161	29.2%	286	109	38.1%	522	109	20.9%	17	4	23.5%
37204	444	161	36.3%	840	371	44.2%	822	419	51.0%	450	111	24.7%	12	2	16.7%
37205	1,332	667	50.1%	2,398	1,251	52.2%	3,653	1,892	51.8%	44	14	31.8%	33	12	36.4%
37206	750	284	37.9%	1,376	529	38.4%	1,558	673	43.2%	557	137	24.6%	11	3	27.3%
37207	920	282	30.7%	1,526	484	31.7%	1,148	471	41.0%	1,280	291	22.7%	18	4	22.2%
37208	519	90	17.3%	966	219	22.7%	53	18	34.0%	1,421	288	20.3%	11	3	27.3%
37209	849	339	39.9%	1,491	628	42.1%	1,846	845	45.8%	461	113	24.5%	33	9	27.3%
37210	435	147	33.8%	893	349	39.1%	978	414	42.3%	330	76	23.0%	20	6	30.0%
37211	1,529	696	45.5%	2,834	1,355	47.8%	4,082	1,973	48.3%	208	55	26.4%	73	23	31.5%
37212	265	97	36.6%	663	266	40.1%	585	274	46.8%	330	84	25.5%	13	5	38.5%
37213	1	0	0.0%	4	1	25.0%	3	1	33.3%	2	0	0.0%	.	.	.
37214	972	466	47.9%	1,576	755	47.9%	2,495	1,211	48.5%	42	6	14.3%	11	4	36.4%
37215	1,045	514	49.2%	1,914	963	50.3%	2,903	1,460	50.3%	27	7	25.9%	29	10	34.5%
37216	764	307	40.2%	1,316	539	41.0%	1,802	776	43.1%	260	60	23.1%	18	10	55.6%
37217	522	227	43.5%	914	416	45.5%	1,310	611	46.6%	112	31	27.7%	14	1	7.1%
37218	549	160	29.1%	974	295	30.3%	483	176	36.4%	1,029	275	26.7%	11	4	36.4%
37219	38	15	39.5%	70	19	27.1%	74	27	36.5%	30	6	20.0%	4	1	25.0%
37220	413	215	52.1%	617	332	53.8%	1,020	541	53.0%	3	1	33.3%	7	5	71.4%
37221	790	403	51.0%	1,365	667	48.9%	2,079	1,038	49.9%	47	21	44.7%	29	11	37.9%
37222	21	10	47.6%	33	15	45.5%	46	23	50.0%	8	2	25.0%	.	.	.
37224	20	4	20.0%	18	9	50.0%	25	12	48.0%	13	1	7.7%	.	.	.
37227	6	1	16.7%	4	2	50.0%	6	1	16.7%	3	1	33.3%	1	1	100.0%
37228	60	14	23.3%	128	47	36.7%	47	15	31.9%	139	45	32.4%	2	1	50.0%
37229	9	5	55.6%	7	2	28.6%	13	6	46.2%	3	1	33.3%	.	.	.
37230	.	.	.	5	2	40.0%	5	2	40.0%	.	.	.	.	.	.
37237	2	1	50.0%	.	.	.	2	1	50.0%	.	.	.	.	.	.
37243	1	0	0.0%	.	.	.	.	.	.	1	0	0.0%	.	.	.
TOTAL	20,484	8,297	40.5%	35,099	15,097	43.0%	46,577	21,224	45.6%	8,430	1,999	23.7%	576	171	29.7%

* Race categories based on national Enrollment Data Base (EDB) race code.

Data Table 81. Chlamydia Cases Reported to MPHD by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

	Chlamydia Cases																							
	Total*	Males	Females	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
				Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	1,926	495	1,431	1,317	395	922	569	91	478	30	8	22	7	3	4	1,316	394	922	568	91	477	32	9	23
1996	1,965	537	1,428	1,361	413	948	557	107	450	31	10	21	8	3	5	1,361	413	948	555	107	448	34	10	24
1997	1,820	512	1,308	1,311	411	900	405	74	331	33	18	15	3	1	2	1,310	411	899	404	74	330	35	18	17
1998	1,981	555	1,426	1,409	457	952	514	77	437	54	20	34	5	1	4	1,409	457	952	512	77	435	56	20	36
1999	2,202	574	1,628	1,490	432	1,058	562	113	449	64	18	46	51	13	38	1,475	428	1,047	543	110	433	99	25	74
2000	2,403	645	1,758	1,745	511	1,234	558	113	445	40	15	25	59	15	44	1,724	502	1,222	532	113	419	87	24	63
2001	2,086	549	1,537	1,470	407	1,063	443	106	337	62	23	39	56	16	40	1,466	405	1,061	415	99	316	94	32	62

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

* Total includes the following number of cases with unknown race: 10 in 1995, 16 in 1996, 71 in 1997, 4 in 1998, 86 in 1999, 60 in 2000, and 108 in 2001. The following cases with unknown race reported Hispanic ethnicity: 1 in 1996 and 1 in 1999. Total also includes 1 case in 1995 with unknown age.

Data Table 82. Chlamydia Cases Among 15-24 Year Olds Reported to MPHD by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

Year	Chlamydia Cases																							
	Total	Male	Female	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
				Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	1,443	334	1,109	993	273	720	424	56	368	19	4	15	5	2	3	992	272	720	424	56	368	20	5	15
1996	1,477	356	1,121	1,046	291	755	405	58	347	18	5	13	3	1	2	1,046	291	755	404	58	346	19	5	14
1997	1,355	337	1,018	995	285	710	286	34	252	21	12	9	3	1	2	994	285	709	285	34	251	23	12	11
1998	1,500	364	1,136	1,073	303	770	391	50	341	34	11	23	3	0	3	1,073	303	770	390	50	340	35	11	24
1999	1,656	365	1,291	1,130	283	847	421	66	355	34	7	27	26	6	20	1,122	281	841	408	64	344	55	11	44
2000	1,827	422	1,405	1,353	351	1,002	413	64	349	21	6	15	40	9	31	1,338	344	994	394	64	330	55	13	42
2001	1,538	328	1,210	1,075	237	838	335	69	266	42	14	28	42	10	32	1,071	235	836	315	65	250	66	20	46

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

* Total includes the following number of cases with unknown race: 7 in 1995, 8 in 1996, 53 in 1997, 2 in 1998, 71 in 1999, 40 in 2000, and 84 in 2001.

Data Table 83. Chlamydia Cases Reported to MPHD by Age Group and Gender, Nashville, TN, 1995-2000

Year	Chlamydia Cases								
	Aged 25-34			Aged 35-44			Aged 45+		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	314	117	197	66	30	36	21	9	12
1996	349	129	220	66	36	30	12	9	3
1997	333	132	201	66	30	36	13	9	4
1998	337	132	205	78	43	35	13	10	3
1999	383	148	235	79	41	38	22	17	5
2000	410	168	242	85	37	48	26	16	10
2001	384	149	235	89	50	39	29	20	9

Data Table 84. Chlamydia Rates** by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

Year	Chlamydia Rates** / 100,000 Population																							
	Total	Males	Females	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
				Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	361.82	196.32	510.77	^	^	^	^	^	^	^	^	^	^	^	^	1,007.82	659.06	1,302.32	145.26	48.68	233.71	298.81	165.41	436.60
1996	367.27	211.99	506.89	^	^	^	^	^	^	^	^	^	^	^	^	1,027.41	681.77	1,318.66	141.69	57.15	219.10	312.99	181.46	448.43
1997	341.02	202.71	465.29	^	^	^	^	^	^	^	^	^	^	^	^	982.49	674.82	1,241.20	103.75	39.76	162.33	319.99	324.68	315.16
1998	371.00	219.72	506.81	^	^	^	^	^	^	^	^	^	^	^	^	1,046.86	744.07	1,301.01	131.85	41.49	214.56	507.06	357.85	659.95
1999	415.43	229.01	582.66	^	^	^	^	^	^	^	^	^	^	^	^	1,094.40	696.64	1,427.62	141.33	59.91	215.85	895.68	447.39	1,354.07
2000	421.66	233.81	597.91	1,181.48	744.27	1,561.27	146.16	61.15	225.90	98.98	66.91	138.93	226.13	94.14	433.16	1,173.28	735.40	1,553.19	143.34	63.29	217.54	167.95	82.57	277.08
2001	366.03	199.01	522.74	995.29	592.79	1,344.92	116.03	57.36	171.07	153.42	102.60	216.73	214.63	100.42	393.78	997.69	593.30	1,348.55	111.81	55.45	164.06	181.46	110.10	272.68

** All rates are per 100,000 population.

^ Data unavailable; population data for the calculation of rates was not available for the specified race groups.

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

Data Table 85. Chlamydia Rates* Among 15-24 Year Olds by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

Year	Chlamydia Rates** / 100,000 Population																							
	Total	Male	Female	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
				Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	1,869.73	878.58	2,831.90	^	^	^	^	^	^	^	^	^	^	^	^	4,270.16	2,485.61	5,859.38	817.13	215.83	1,418.49	972.29	443.66	1,612.90
1996	1,921.50	939.93	2,874.95	^	^	^	^	^	^	^	^	^	^	^	^	4,457.32	2,627.07	6,093.62	787.22	226.07	1,348.19	913.46	437.83	1,492.54
1997	1,783.34	899.89	2,641.96	^	^	^	^	^	^	^	^	^	^	^	^	4,224.93	2,561.34	5,717.74	565.84	135.05	996.31	1,102.59	1,046.21	1,171.46
1998	1,991.26	980.10	2,974.60	^	^	^	^	^	^	^	^	^	^	^	^	4,536.04	2,702.70	6,187.72	786.61	201.82	1,370.69	1,671.44	954.03	2,550.48
1999	2,234.79	998.77	3,437.53	^	^	^	^	^	^	^	^	^	^	^	^	4,755.04	2,508.03	6,786.64	842.71	264.59	1,419.90	2,631.58	954.03	4,695.84
2000	2,127.49	987.55	3,256.54	5,120.15	2,860.17	7,079.77	807.65	250.44	1,364.29	252.56	122.32	439.88	601.68	205.10	1,371.68	5,095.20	2,820.83	7,067.19	810.83	267.42	1,338.20	498.91	196.82	950.44
2001	1,790.95	767.57	2,804.56	4,068.12	1,931.23	5,921.01	655.12	270.01	1,039.83	505.11	285.42	821.11	631.77	227.89	1,415.93	4,078.45	1,927.02	5,943.83	648.25	271.60	1,013.79	598.69	302.80	1,040.96

** All rates are per 100,000 population.

^ Data unavailable; population data for the calculation of rates was not available for the specified race groups.

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

Data Table 86. Chlamydia Rates* by Age Group and Gender, Nashville, TN, 1995-2000

Year	Chlamydia Rates** / 100,000 Population								
	Aged 25-34			Aged 35-44			Aged 45+		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	330.17	252.06	404.64	75.43	70.77	79.82	12.69	12.74	12.65
1996	398.87	304.30	487.76	74.23	83.78	65.29	7.15	12.55	3.12
1997	369.12	299.97	434.96	73.62	69.43	77.53	7.70	12.46	4.14
1998	384.10	308.55	455.99	86.05	98.66	74.38	7.63	13.71	3.08
1999	452.64	358.84	541.84	86.90	94.02	80.34	12.90	23.26	5.13
2000	409.23	329.07	492.53	90.91	80.02	101.56	14.16	19.73	9.76
2001	383.28	291.85	478.28	95.19	108.14	82.52	15.80	24.66	8.78

** All rates are per 100,000 population.

Data Table 87. Gonorrhea Cases Reported to MPHD by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

	Gonorrhea Cases																							
	Total*	Males	Females	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
				Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	2,622	1,587	1,035	2,205	1,396	809	382	168	214	27	18	9	4	4	0	2,205	1,396	809	382	168	214	27	18	9
1996	2,033	1,254	779	1,647	1,049	598	346	173	173	27	22	5	5	4	1	1,647	1,049	598	345	173	172	28	22	6
1997	2,050	1,205	845	1,690	1,021	669	282	141	141	19	15	4	5	4	1	1,688	1,019	669	281	140	141	22	18	4
1998	1,777	1,059	718	1,435	895	540	312	142	170	23	15	8	1	0	1	1,435	895	540	311	142	169	24	15	9
1999	1,785	1,049	736	1,390	858	532	295	139	156	31	27	4	16	13	3	1,384	854	530	292	137	155	40	33	7
2000	2,404	1,388	1,016	1,979	1,179	800	368	184	184	15	11	4	31	25	6	1,961	1,165	796	360	177	183	41	32	9
2001	1,625	873	752	1,246	678	568	285	137	148	25	21	4	15	11	4	1,246	678	568	279	134	145	31	24	7

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

* Total includes the following number of cases with unknown race; 8 in 1995, 13 in 1996, 59 in 1997, 7 in 1998, 69 in 1999, 42 in 2000, and 69 in 2001.

Data Table 88. Gonorrhea Cases Among 15-24 Year Olds Reported to MPHD by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

Year	Gonorrhea Cases																							
	Total	Male	Female	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
				Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	1,360	711	649	1,147	643	504	193	58	135	13	6	7	3	3	0	1,147	643	504	193	58	135	13	6	7
1996	1,018	551	467	852	482	370	154	59	95	10	8	2	2	2	0	852	482	370	154	59	95	10	8	2
1997	1,121	569	552	953	503	450	118	41	77	13	10	3	2	1	1	953	503	450	117	40	77	14	11	3
1998	958	486	472	801	435	366	144	42	102	10	6	4	1	0	1	801	435	366	143	42	101	11	6	5
1999	951	473	478	770	418	352	129	36	93	12	9	3	8	7	1	765	414	351	128	35	93	18	14	4
2000	1,345	651	694	1,141	579	562	174	61	113	9	6	3	15	12	3	1,135	574	561	168	56	112	21	16	5
2001	941	412	529	756	339	417	133	47	86	11	10	1	5	3	2	756	339	417	130	46	84	14	11	3

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

* Total includes the following number of cases with unknown race; 7 in 1995, 2 in 1996, 37 in 1997, 3 in 1998, 40 in 1999, 21 in 2000, and 41 in 2001.

Data Table 89. Gonorrhea Cases Reported to MPHD by Age Group and Gender, Nashville, TN, 1995-2000

Year	Gonorrhea Cases								
	Aged 25-34			Aged 35-44			Aged 45+		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	721	474	247	366	284	82	116	106	10
1996	558	346	212	322	258	64	94	88	6
1997	476	299	177	322	251	71	90	80	10
1998	489	320	169	237	186	51	68	60	8
1999	471	304	167	243	186	57	87	79	8
2000	607	402	205	301	227	74	112	98	14
2001	369	236	133	193	133	60	98	88	10

Data Table 90. Gonorrhea Rates** by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

Gonorrhea Rates** / 100,000 Population																								
Year	Total	Males	Females	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
				Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	492.57	629.41	369.42	^	^	^	^	^	^	^	^	^	^	^	^	1,688.63	2,335.15	1,142.70	97.69	89.88	104.85	252.12	330.82	170.84
1996	379.97	495.03	276.52	^	^	^	^	^	^	^	^	^	^	^	^	1,243.31	1,731.65	831.81	88.08	92.40	84.12	257.76	399.20	112.11
1997	384.12	477.09	300.59	^	^	^	^	^	^	^	^	^	^	^	^	1,265.98	1,673.10	923.65	72.16	75.22	69.36	201.13	324.68	74.16
1998	332.79	419.24	255.18	^	^	^	^	^	^	^	^	^	^	^	^	1,066.18	1,457.20	737.97	80.09	76.51	83.36	217.31	268.38	164.99
1999	336.76	418.52	263.42	^	^	^	^	^	^	^	^	^	^	^	^	1,026.88	1,390.02	722.67	76.00	74.61	77.27	361.89	590.55	128.09
2000	421.84	503.14	345.55	1,339.91	1,717.21	1,012.17	96.39	99.57	93.40	37.12	49.07	22.23	118.81	156.91	59.07	1,334.57	1,706.66	1,011.73	97.00	99.14	95.01	79.15	110.10	39.58
2001	285.14	316.46	255.76	843.62	987.50	718.64	74.65	74.14	75.13	61.86	93.68	22.23	57.49	69.04	39.38	847.97	993.23	721.94	75.17	75.05	75.28	59.84	82.57	30.79

** All rates are per 100,000 population.

^ Data unavailable; population data for the calculation of rates was not available for the specified race groups.

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

Data Table 91. Gonorrhea Rates* Among 15-24 Year Olds by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

Data Table 31: Gonorrhea Rates** Among 15-24 Year Olds by Race, Ethnicity and Gender, Nashville, TN, 1995-2000																								
Year	Gonorrhea Rates** / 100,000 Population																							
	Total	Male	Female	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
				Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	1,762.18	1,870.27	1,657.26	^	^	^	^	^	^	^	^	^	^	^	^	4,937.37	5,875.90	4,101.56	371.95	223.54	520.37	631.99	532.39	752.69
1996	1,324.37	1,454.79	1,197.68	^	^	^	^	^	^	^	^	^	^	^	^	3,630.63	4,351.36	2,986.28	300.08	229.97	370.17	480.77	700.53	213.22
1997	1,475.37	1,519.40	1,432.58	^	^	^	^	^	^	^	^	^	^	^	^	4,050.67	4,520.54	3,629.03	232.29	158.89	305.64	671.14	959.02	319.49
1998	1,271.75	1,308.60	1,235.93	^	^	^	^	^	^	^	^	^	^	^	^	3,386.18	3,880.12	2,941.18	288.42	169.53	407.18	525.31	520.38	531.35
1999	1,283.38	1,294.29	1,272.77	^	^	^	^	^	^	^	^	^	^	^	^	3,242.07	3,695.11	2,832.47	264.38	144.70	383.87	861.24	1,214.22	426.89
2000	1,566.21	1,523.45	1,608.57	4,317.88	4,718.06	3,970.89	340.27	238.70	441.73	108.24	122.32	87.98	225.63	273.47	132.74	4,322.16	4,706.85	3,988.62	345.74	234.00	454.18	190.49	242.24	113.15
2001	1,095.77	964.15	1,226.13	2,860.93	2,762.39	2,946.37	260.09	183.92	336.19	132.29	203.87	29.33	75.21	68.37	88.50	2,878.90	2,779.83	2,964.81	267.53	192.21	340.63	127.00	166.54	67.89

** All rates are per 100,000 population.

^ Data unavailable; population data for the calculation of rates was not available for the specified race groups.

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

Data Table 92. Gonorrhea Rates* by Age Group and Gender, Nashville, TN, 1995-2000

Year	Gonorrhea Rates** / 100,000 Population								
	Aged 25-34			Aged 35-44			Aged 45+		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	758.13	1021.18	507.34	418.30	669.92	181.80	70.09	150.06	10.54
1996	599.99	762.50	445.14	362.14	600.45	139.28	56.01	122.73	6.24
1997	527.63	679.48	383.03	359.18	580.86	152.90	53.30	110.78	10.35
1998	557.34	748.00	375.91	261.47	426.77	108.38	39.91	82.27	8.21
1999	556.64	737.08	385.05	267.31	426.53	120.51	51.01	108.11	8.21
2000	605.87	787.42	417.23	321.93	490.95	156.57	61.02	120.86	13.66
2001	368.31	462.26	270.69	206.42	287.65	126.95	53.39	108.52	9.76

** All rates are per 100,000 population.

Data Table 93. Primary and Secondary Syphilis Cases Reported to MPHD by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

Year	Primary & Secondary Syphilis Cases																							
	Total	Males	Females	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
	Total	Males	Females	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	97	54	43	79	45	34	17	9	8	1	0	1	1	1	0	79	45	34	16	8	8	2	1	1
1996	193	96	97	178	85	93	15	11	4	0	0	0	1	1	0	178	85	93	14	10	4	1	1	0
1997	203	106	97	180	95	85	23	11	12	0	0	0	0	0	0	180	95	85	23	11	12	0	0	0
1998	210	117	93	194	110	84	16	7	9	0	0	0	1	1	0	193	109	84	16	7	9	1	1	0
1999	250	148	102	213	131	82	36	17	19	1	0	1	5	4	1	213	131	82	32	13	19	5	4	1
2000	200	117	83	155	95	60	45	22	23	0	0	0	3	3	0	155	95	60	42	19	23	3	3	0
2001	76	47	29	58	35	23	18	12	6	0	0	0	2	2	0	58	35	23	16	10	6	2	2	0

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

Data Table 94. Primary and Secondary Syphilis Cases Reported to MPHD by Age Group and Gender, Nashville, TN, 1995-2000

Year	Primary & Secondary Syphilis Cases											
	Aged 15-24 Years			Aged 25-34			Aged 35-44			Aged 45+		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	20	9	11	32	17	15	34	20	14	11	8	3
1996	39	16	23	78	34	44	58	32	26	18	14	4
1997	48	16	32	72	35	37	62	38	24	20	17	3
1998	49	22	27	56	24	32	65	40	25	40	31	9
1999	31	12	19	82	38	44	98	65	33	37	32	5
2000	48	21	27	60	32	28	56	34	22	36	30	6
2001	15	8	7	20	9	11	24	15	9	17	15	2

Data Table 95. Primary and Secondary Syphilis Rates** by Race / Ethnicity and Gender, Nashville, TN, 1995-2000

Year	Primary & Secondary Syphilis Rates** / 100,000 Population																							
	Total	Males	Females	Black			White			Other+			Hispanic			Black Non-Hispanic			White Non-Hispanic			Other+ & Hispanic		
	Total	Males	Females	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	18.22	21.42	15.35	^	^	^	^	^	^	^	^	^	^	^	^	60.50	75.27	48.02	4.09	4.28	3.92	18.68	18.38	18.98
1996	36.07	37.90	34.43	^	^	^	^	^	^	^	^	^	^	^	^	134.37	140.31	129.36	3.57	5.34	1.96	9.21	18.15	0.00
1997	38.04	41.97	34.51	^	^	^	^	^	^	^	^	^	^	^	^	135.00	155.98	117.35	5.91	5.91	5.90	0.00	0.00	0.00
1998	39.33	46.32	33.05	^	^	^	^	^	^	^	^	^	^	^	^	143.40	177.47	114.79	4.12	3.77	4.44	9.05	17.89	0.00
1999	47.17	59.05	36.51	^	^	^	^	^	^	^	^	^	^	^	^	158.04	213.22	111.81	8.33	7.08	9.47	45.24	71.58	18.30
2000	35.09	42.41	28.23	104.95	138.37	75.91	11.79	11.91	11.68	0.00	0.00	0.00	11.50	18.83	0.00	105.49	139.17	76.26	11.32	10.64	11.94	5.79	10.32	0.00
2001	13.34	17.04	9.86	39.27	50.98	29.10	4.71	6.49	3.05	0.00	0.00	0.00	7.67	12.55	0.00	39.47	51.27	29.23	4.31	5.60	3.12	3.86	6.88	0.00

** All rates are per 100,000 population.

^ Data unavailable; population data for the calculation of rates was not available for the specified race groups.

+ Other includes Asian/Pacific Islander, American Indian/Alaska Native and other unspecified race categories.

Data Table 96. Primary and Secondary Syphilis Rates* by Age Group and Gender, Nashville, TN, 1995-2000

Year	Primary & Secondary Syphilis Rates* / 100,000 Population											
	Aged 15-24 Years			Aged 25-34			Aged 35-44			Aged 45+		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1995	25.91	23.67	28.09	33.65	36.62	30.81	38.86	47.18	31.04	6.65	11.33	3.16
1996	50.74	42.24	58.99	83.87	74.93	92.39	65.23	74.47	56.58	10.73	19.53	4.16
1997	63.17	42.72	83.05	79.81	79.54	80.07	69.16	87.94	51.68	11.84	23.54	3.10
1998	65.05	59.24	70.70	63.83	56.10	71.18	71.71	91.78	53.13	23.48	42.50	9.24
1999	41.83	32.84	50.59	96.91	92.13	101.45	107.80	149.06	69.77	21.70	43.79	5.13
2000	55.89	49.14	62.58	59.89	62.68	56.99	59.89	73.53	46.55	19.61	37.00	5.86
2001	17.47	18.72	16.22	19.96	17.63	22.39	25.67	32.44	19.04	9.26	18.50	1.95

** All rates are per 100,000 population.

Data Table 97. HIV and AIDS Cases and Rates* by Date of Report and Date of Diagnosis, Nashville, TN, 1990-2000

Year	Population	Number of Cases				Rate*/100,000 Population			
		Report		Diagnosis		Report		Diagnosis	
		AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV
1990	510,784	86	^	112	^	16.8	^	21.9	^
1991	512,402	100	^	124	^	19.5	^	24.2	^
1992	517,274	111	209	196	318	21.5	40.4	37.9	61.5
1993	522,596	254	319	238	285	48.6	61.0	45.5	54.5
1994	528,292	179	332	192	325	33.9	62.8	36.3	61.5
1995	532,307	247	327	264	313	46.4	61.4	49.6	58.8
1996	535,036	220	220	252	226	41.1	41.1	47.1	42.2
1997	533,689	237	241	224	242	44.4	45.2	42.0	45.3
1998	533,967	147	203	177	285	27.5	38.0	33.1	53.4
1999	530,050	191	245	156	176	36.0	46.2	29.4	33.2
2000	569,891	277	248	163	216	48.6	43.5	28.6	37.9

* All rates are per 100,000 population.

^ Data not available; HIV was not reportable in TN until 1992.

Data Table 98. HIV and AIDS Cases and Rates* by Subgroup, Nashville, TN, 2000

	Population	Number of Cases		Rate* / 100,000 Population	
		HIV	AIDS	HIV	AIDS
TOTAL	569,891	248	277	43.5	48.6
RACE / ETHNICITY					
Black, non-Hispanic	146,939	144	135	98.0	91.9
White, non-Hispanic	371,150	96	135	25.9	36.4
Other+ & Hispanic	51,802	8	7	15.4	13.5
GENDER					
Male	275,865	180	224	65.2	81.2
Female	294,026	68	53	23.1	18.0

* All rates are per 100,000 population.

^ Data not available; HIV was not reportable in TN until 1992.

+ Other includes Asian/Pacific Islanders, American Indian/Alaska Natives and Other unspecified race groups.

Data Table 99. Number of New Cancer Cases and Number of Cancer Deaths by Gender and Race, Nashville, TN, 1992-1996

	# of New Cases	% of All Cases	# of Deaths	Deaths as % of New Cases
All	11,304		5,609	49.6
Male	5,565	49.2	2,887	51.9
Female	5,738	50.8	2,722	47.4
White	9,151	81.0	4,310	47.1
Non-White	2,142	18.9	1,299	60.6
White Male	4,487	39.7	2,193	48.9
White Female	4,663	41.3	2,117	45.4
Non-White Male	1,068	9.4	694	65.0
Non-White Female	1,074	9.5	605	56.3

Data Source: Tennessee Cancer Reporting System

Data Table 100. Leading Cancer Sites: Number of Cancer Cases and Age-adjusted Cancer Incidence Rate, Nashville, TN, 1992-1996

		Number	Percent	A- Rate*
1	Lung	2,091	18.5	75.8
2	Female Breast	1,800	15.9	110.6
3	Prostate	1,458	12.9	133.0
4	Colon	986	8.7	33.8
5	Bladder	406	3.6	13.8
6	Non Hodgkins Lymphomas	403	3.6	13.6
7	Rectum	372	3.3	13.0
8	Oral Cavity	306	2.7	11.0
9	Corpus Uteri	304	2.7	18.8
10	Melanoma	261	2.3	9.0
11	Kidney	260	2.3	9.2
12	Leukemias	229	2.0	8.0
13	Pancreas	207	1.8	7.1
14	Nervous System	204	1.8	7.4
15	Ovary	192	1.7	11.8
16	Stomach & Small Intestine	175	1.5	6.1
17	Cervix	161	1.4	9.6
18	Myelomas	130	1.2	4.6
19	Esophagus	124	1.1	4.6
20	Testis	54	0.5	3.3
21	Hodgkins Disease	82	0.7	2.7
22	Liver	57	0.5	2.2
23	Bone	21	0.2	0.8
	Other Sites	1,021	9.0	35.2
	All	11,304	100.0	398.0

* A-Rate: Age-adjusted Cancer Incidence Rate (Adjusted to 1970 U.S. population)

Data Table 101. Ten Leading Cancer Sites: Number of Cancer Cases and Age-adjusted Cancer Incidence Rate by Gender, Nashville, TN, 1992-1996

Male	Number	A-Rate*	Female	Number	A-Rate*
Prostate	1,458	133.0	Female Breast	1,800	110.6
Lung	1,249	112.2	Lung	842	51.6
Colon	453	40.3	Colon	533	29.5
Bladder	287	25.5	Corpus Uteri	304	18.8
Oral Cavity	217	18.8	Non Hodgkins Lymphomas	210	12.0
Rectum	197	17.4	Ovary	192	11.8
Non Hodgkins Lymphomas	193	15.7	Rectum	175	10.0
Kidney	149	12.5	Cervix	161	9.6
Melanoma	141	11.8	Melanoma	120	7.3
Leukemias	112	10.1	Bladder	119	6.2
All	5,565	490.3	All	5,738	342.9

*A-Rate: Age-adjusted Cancer Incidence Rate (Adjusted to 1970 U.S. population)

Data Table 102. Ten Leading Cancer Sites: Number of Cancer Cases and Age-adjusted Cancer Incidence Rate by Race, Nashville, TN, 1992-1996

White	Number	A-Rate*	Non-white	Number	A-Rate*
Lung	1,707	75.8	Lung	383	75.2
Female Breast	1,471	113.5	Female Breast	328	98.2
Prostate	1,154	127.6	Prostate	302	156.9
Colon	804	33.4	Colon	181	34.5
Bladder	347	14.5	Rectum	72	13.1
Non Hodgkins Lymphomas	334	14.0	Oral Cavity	69	12.3
Rectum	300	12.9	Non Hodgkins Lymphomas	69	11.5
Corpus Uteri	257	19.7	Bladder	58	10.8
Melanoma	254	11.0	Kidney	56	10.0
Oral Cavity	237	10.6	Corpus Uteri	47	15.5
All	9,151	397.3	All	2,142	398

*A-Rate: Age-adjusted Cancer Incidence Rate (Adjusted to 1970 U.S. population)

Data Table 103. Age-adjusted Cancer Incidence Rate by Gender/Race and Year, Nashville, TN, 1992-1996

	1992	1993	1994	1995	1996
All	440.3	396.0	373.6	389.4	391.2
Male	572.6	513.8	442.3	456.1	468.3
Female	363.8	323.0	332.7	350.1	345.1
White	442.0	397.5	381.2	376.1	390.1
Non-White	427.3	383.4	341.3	443.1	395.1
White Male	562.8	509.8	443.8	438.5	466.7
White Female	375.9	328.0	345.3	341.0	346.9
Non-White Male	610.6	517.7	433.0	528.9	474.0
Non-White Female	311.8	302.1	285.2	387.9	341.2

Data Table 104. Age-adjusted* Cancer Incidence Rate by Site and Year, Nashville, TN, 1992-1996

	1992	1993	1994	1995	1996
Lung	74.8	80.2	75.9	72.2	75.6
Prostate	173.2	137.8	122.3	119.7	113.2
Female Breast	117.7	112.9	102.9	104.2	114.7
Colon	35.6	34.1	29.2	33.7	36.1
Non-hodgkins Lymphomas	15.2	15.1	12.4	12.7	12.8
Bladder	12.8	13.8	16.4	13.9	12.0
Rectum	12.3	12.0	12.0	15.1	13.7
Melanomas	11.3	8.3	7.2	8.5	9.8
Kidney	11.4	9.4	8.2	8.7	8.4
Corpus Uteri	19.0	21.4	19.0	16.7	18.1
Oral cavity	10.3	11.5	9.0	12.4	11.8
Ovary	9.8	10.7	14.0	12.5	11.8
Leukemias	10.5	6.7	6.8	8.8	7.2
Pancreas	8.7	5.8	6.8	7.3	6.7
Nervous System	8.2	7.2	5.6	8.0	8.2
Cervix	11.0	7.8	9.4	8.4	11.6

*Adjusted to 1970 U.S. population

Data Table 105. Cancer Incidence, Age-adjusted* Rate, Tennessee, Shelby, Knox, Hamilton Counties, and Nashville, 1992-1996

	Nashville	TN	Shelby	Knox	Hamilton
All	398.0	337.1	350.0	377.8	351.5
Male	490.3	401.0	410.2	463.8	423.2
Female	342.9	296.6	316.6	327.2	309.7
White	397.3	333.5	340.2	377.9	344.9
Other	398.0	358.3	364.8	353.7	381.3
White Male	484.1	393.2	390.9	461.1	409.8
White Female	347.3	296.1	315.4	329.1	307.8
Non-White Male	512.6	457.0	448.0	462.0	503.0
Non-White Female	325.9	296.9	315.5	291.7	310.9

*Adjusted to 1970 U.S. population

Data Table 106. Lung Cancer Incidence, Age-adjusted Rate, Tennessee, Shelby, Knox, Hamilton Counties, and Nashville, 1992-1996

	1992	1993	1994	1995	1996
Nashville	74.8	80.2	75.9	72.2	75.6
Tennessee	62.2	63.7	63.1	64.2	66.6
Shelby	58.1	66.5	60.2	66.8	57.7
Knox	73.3	76.1	71.1	68.4	72.0
Hamilton	59.9	67.8	66.0	69.3	71.1

Data Table 107. Female Breast Cancer Incidence, Age-adjusted Rate, Tennessee, Shelby, Knox, Hamilton Counties, and Nashville, 1992-1996

	1992	1993	1994	1995	1996
Nashville	117.7	112.9	102.9	104.2	114.7
Tennessee	93.3	92.9	91.7	94.4	93.9
Shelby	102.7	111.7	102.2	97.7	101.2
Knox	105.7	119.8	97.2	100.6	97.7
Hamilton	117.1	107.0	102.7	112.8	98.8

Data Table 108. Prostate Cancer Incidence, Age-adjusted Rate, Tennessee, Shelby, Knox, Hamilton Counties, and Nashville, TN, 1992-1996

	1992	1993	1994	1995	1996
Nashville	173.2	137.8	122.3	119.7	113.2
Tennessee	123.6	104.1	90.0	90.3	88.7
Shelby	125.4	108.9	90.0	91.2	104.6
Knox	177.1	155.5	115.5	107.3	140.0
Hamilton	87.5	115.4	116.1	138.9	109.2

Data Table 109. Colon Cancer Incidence, Age-adjusted Rate, Tennessee, Shelby, Knox, Hamilton Counties, and Nashville, 1992-1996

	1992	1993	1994	1995	1996
Nashville	35.6	34.1	29.2	33.7	36.1
Tennessee	28.8	28.9	28.5	28.4	29.3
Shelby	32.1	32.9	32.0	32.0	32.1
Knox	33.5	33.1	26.7	28.9	29.5
Hamilton	25.9	25.5	26.3	25.7	23.5

Data Table 110. Bladder Cancer Incidence, Age-adjusted Rate, Tennessee, Shelby, Knox, Hamilton Counties, and Nashville, 1992-1996

	1992	1993	1994	1995	1996
Nashville	12.8	13.8	16.4	13.9	12.0
Tennessee	13.2	13.4	13.5	12.7	12.9
Shelby	13.1	11.5	11.1	12.7	13.9
Knox	14.1	13.7	13.5	10.9	15.0
Hamilton	13.2	10.8	14.1	10.5	10.6

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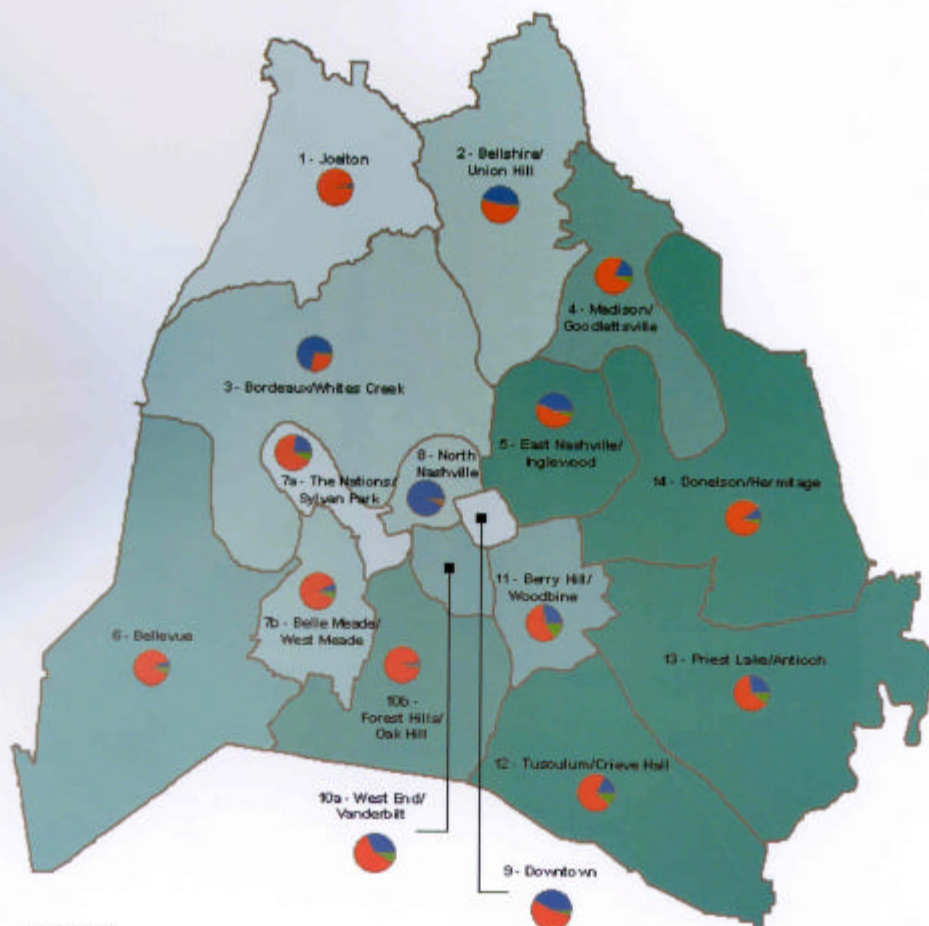
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Census Tracts in Davidson County, TN, 2000

TRACT	LAND AREA	TOTAL AREA	TOTAL POP	BLACK	WHITE	OTHER
191.01	43.9	43.9	6697	188	5322	87
191.02	19.3	19.3	6080	434	1612	127
192	35.9	35.9	7325	862	1222	144
193.01	3.3	3.3	3387	225	2811	81
193.02	3.4	3.4	5988	955	4852	281
194.01	3.7	3.7	3432	697	2625	322
194.02	1.2	1.2	5240	1003	3808	429
195.01	6.0	7.4	5236	193	4897	116
195.02	2.7	3.1	4285	419	3735	138
196	7.6	6.1	7396	1480	5688	418
197.01	1.3	1.3	4222	397	3307	316
197.02	1.8	1.1	3327	758	2122	449
198.01	2.1	2.2	3228	1361	3054	265
198.02	2.8	2.8	3031	442	2550	97
199.01	2.1	2.1	2961	373	2524	115
199.02	2.6	2.6	4916	4004	791	148
199.04	0.8	0.8	2736	2379	301	57
199.05	2.9	2.9	6943	5276	2639	428
199.06	1.4	1.4	2371	732	1556	83
199.07	1.6	1.7	4219	321	3666	187
199.08	1.2	1.2	4168	524	3287	185
199.09	1.7	1.7	5514	2415	2941	458
199.10	1.0	1.0	5330	3205	1928	207
199.11	1.4	1.4	4185	896	3141	152
199.12	3.1	3.2	5157	1591	3320	246
199.13	0.8	0.8	6160	2753	3108	322
199.14	0.8	0.8	4112	3927	286	150
199.15	0.5	0.5	2368	2014	228	226
199.16	0.3	0.3	632	164	714	61
199.17	0.8	0.8	2885	401	2078	150
199.18	1.0	1.0	2348	566	1785	185
199.19	0.4	0.4	2387	548	1323	138
199.20	0.3	0.3	3887	2781	622	211
199.21	1.1	1.1	234	146	78	11
199.22	0.5	0.5	1789	1429	207	52
199.23	3.2	3.2	3367	4914	247	526
199.24	1.8	1.8	2932	1817	375	60
199.25	3.4	3.4	5783	4223	800	113
199.26	5.1	5.2	4307	3139	1268	322
199.27	5.7	6.1	3377	1232	1985	60
199.28	34.2	35.9	1777	163	1517	97
199.29	1.8	1.8	5243	520	4513	679
199.30	1.1	1.1	4377	489	3408	641
199.31	1.4	1.4	3387	86	3227	95
199.32	0.5	0.5	2126	1112	907	147
199.33	1.7	1.8	6885	8858	121	141
199.34	2.5	2.5	5223	4786	306	111
199.35	0.3	0.3	1685	1687	48	18
199.36	0.4	0.4	1153	1688	52	42
199.37	1.0	1.1	2367	1928	352	87
199.38	0.5	0.5	530	385	139	13
199.39	0.4	0.4	2231	2053	151	77
199.40	0.5	0.5	1947	1871	30	46
199.41	0.7	0.7	2571	1889	325	57
199.42	0.6	0.6	77	70	213	74
199.43	0.8	0.8	2306	928	1283	117
199.44	0.5	0.5	334	38	274	6
199.45	0.3	0.3	3221	3028	86	105
199.46	2.2	2.1	561	35	416	50
199.47	2.5	2.6	3130	421	3911	108
199.48	2.8	2.9	4980	212	3889	239
199.49	1.3	1.3	2671	83	2507	101
199.50	6.8	7.4	4362	219	4209	134
199.51	4.3	4.1	5091	351	4484	234
199.52	3.2	3.4	4207	301	3752	154
199.53	1.3	1.5	2429	237	2963	125
199.54	1.3	1.3	3385	469	3242	173
199.55	2.8	2.8	3643	339	3118	165
199.56	2.1	2.1	4141	324	3747	194
199.57	4.4	4.4	2160	1544	5850	496
199.58	1.8	1.8	2748	244	2448	120
199.59	3.8	3.8	5243	368	4551	294
199.60	4.7	4.7	7272	1267	5827	388

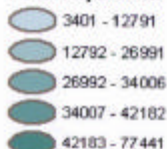
TRACT	LAND AREA	TOTAL AREA	TOTAL POP	BLACK	WHITE	OTHER
199.61	5.5	5.5	5296	965	3826	445
199.62	3.2	3.2	5272	1798	3025	447
199.63	0.7	0.7	3136	823	1580	233
199.64	0.9	0.9	4528	1140	2883	725
199.65	3.9	3.9	6971	2727	3321	818
199.66	1.0	1.0	2638	543	2088	87
199.67	1.5	1.5	5771	1850	3613	313
199.68	2.4	11.3	3905	747	3613	146
199.69	1.4	1.4	5844	728	3935	911
199.70	26.4	27.5	7797	1981	5294	526
199.71	7.6	7.7	1308	156	1238	114
199.72	1.4	1.4	1191	1399	3713	230
199.73	1.6	1.6	3684	638	2643	1192
199.74	2.1	2.1	2579	387	2029	155
199.75	0.5	0.5	1235	894	321	43
199.76	1.2	1.2	2022	886	907	209
199.77	0.7	0.7	3487	2711	580	166
199.78	0.4	0.4	2416	1890	426	91
199.79	0.4	0.4	2982	99	2555	201
199.80	0.6	0.6	3381	351	4023	207
199.81	0.6	0.6	2240	205	1814	221
199.82	1.3	1.3	5370	81	4881	238
199.83	0.7	0.7	4281	93	3929	599
199.84	0.9	0.9	4537	867	3746	224
199.85	0.5	0.5	3077	1802	1344	91
199.86	0.7	0.7	2148	1530	522	84
199.87	1.9	1.9	1852	126	1370	111
199.88	0.9	0.9	3303	453	2026	824
199.89	0.8	0.8	2222	318	1471	433
199.90	1.3	1.3	3309	746	2763	842
199.91	1.1	1.1	3553	311	2817	238
199.92	1.4	1.4	5	1	1	1
199.93	2.3	2.3	6226	88	5996	145
199.94	1.6	1.6	5077	319	4809	149
199.95	1.8	1.8	4347	41	4301	105
199.96	1.5	1.5	4529	45	4385	103
199.97	1.7	1.7	5038	48	4855	137
199.98	1.3	1.3	4790	1036	3623	691
199.99	2.9	2.9	3881	10	3338	143
199.00	2.8	2.8	3007	23	2803	151
199.01	4.1	4.1	5252	641	4345	262
199.02	1.1	1.1	1528	9	1422	17
199.03	22.8	23.3	6562	419	5667	355
199.04	2.5	2.5	5882	284	5274	494
199.05	6.2	6.2	4331	313	3738	285
199.06	2.6	2.6	4398	125	4239	194
199.07	1.8	1.8	5213	236	5628	351
199.08	3.2	3.2	3974	132	3544	150
199.09	2.4	2.4	3508	133	2755	180
199.10	4.1	4.1	5307	98	5620	98
199.11	4.1	4.1	2386	24	2183	81
199.12	8.8	8.8	4183	29	4032	81
199.13	7.6	7.7	3278	26	3244	86
199.14	1.3	1.3	4613	70	4528	75
199.15	3.2	3.2	6001	353	5316	352
199.16	1.3	1.3	2735	301	2191	243
199.17	0.8	0.8	2923	183	2109	211
199.18	1.6	1.6	7543	1024	4588	1037
199.19	1.4	1.4	7364	7138	344	1022
199.20	0.8	0.8	4211	304	2201	909
199.21	1.1	1.1	3884	818	2363	575
199.22	0.8	0.8	4632	720	3399	552
199.23	0.7	0.7	3618	207	3594	371
199.24	4.3	4.3	4616	1303	3012	445
199.25	0.8	0.8	2251	1023	1124	414
199.26	0.9	0.9	4485	881	3904	582
199.27	1.0	1.0	3235	588	2423	340
199.28	0.9	0.9	3865	880	2543	442
199.29	2.5	2.5	2866	682	1447	307
199.30	3.7	3.7	4627	1107	3435	380
199.31	11.4	11.4	1984	122	1756	87
TOTAL	502.3	528.1	589,891	147,696	391,783	48,412

Public Health Planning Districts In Davidson County, TN, 2000

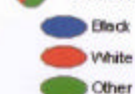


LEGEND

Total Population

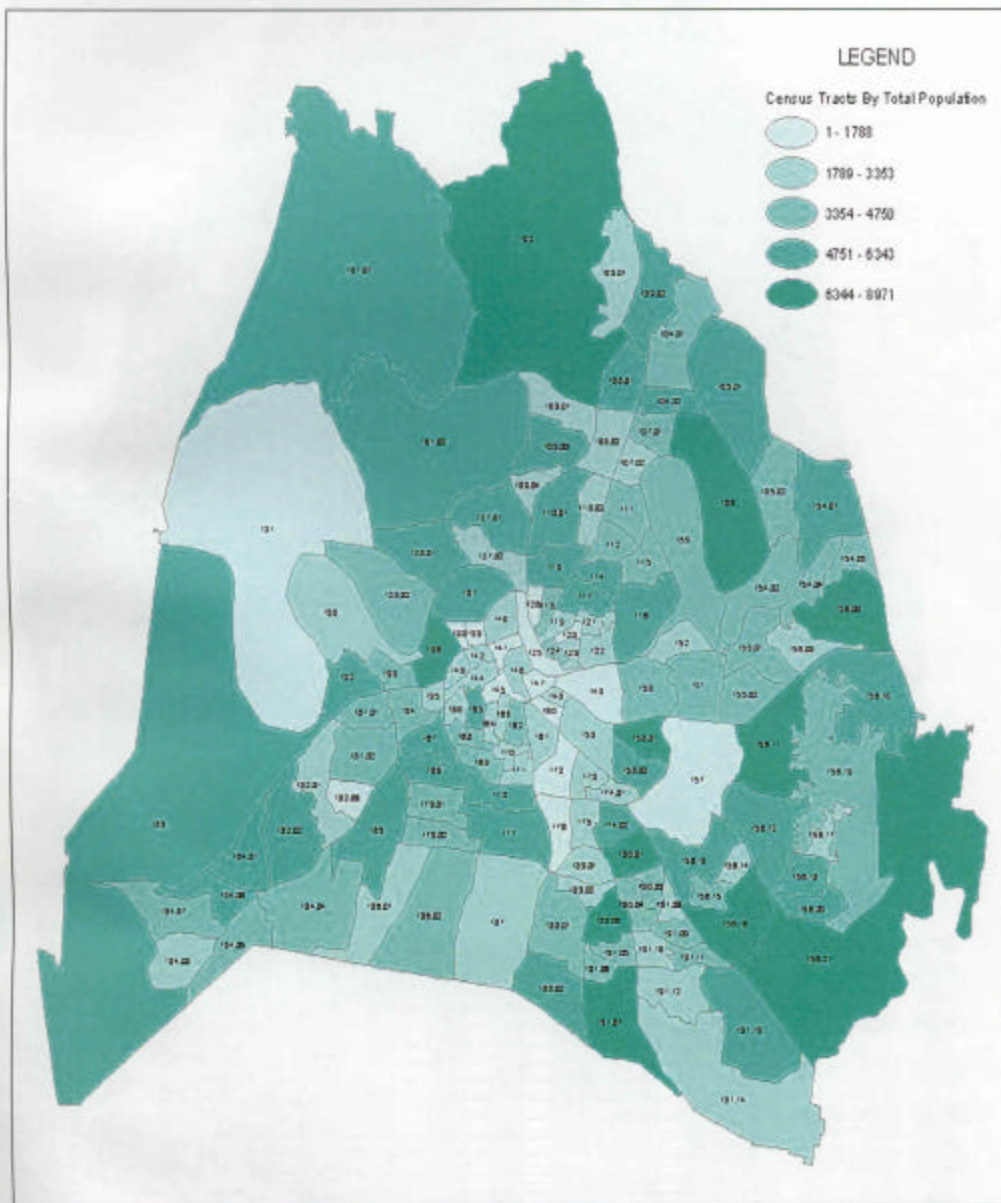


Race Ratio

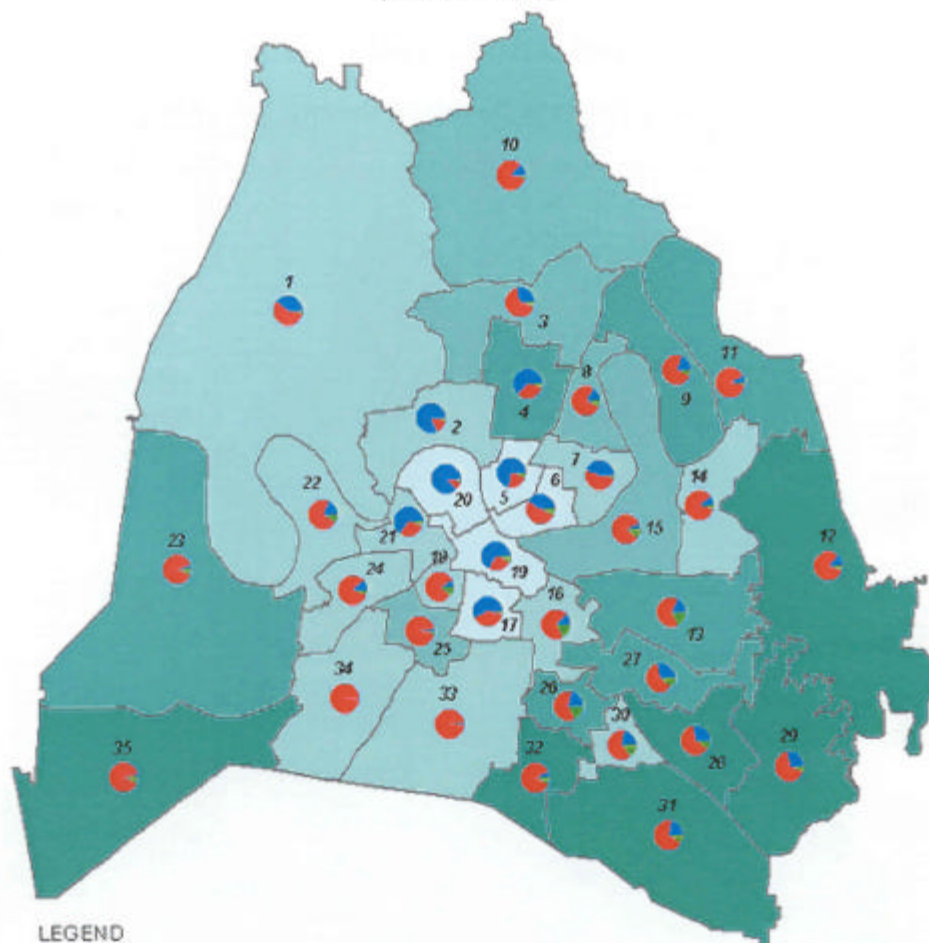


Public Health Planning Distid	Area (sq. mi.)	Population			
		Total	Black	White	Other
1 Joelton	39.6	5,026	199	4,779	78
2 Bellshire/Union Hill	42.0	17,820	9,206	9,061	483
3 Bordeaux/Whites Creek	71.4	25,229	16,282	6,344	603
4 Madison/Goodlettsville	28.7	41,229	7,304	31,277	2,648
5 East Nashville/Inglewood	20.6	64,940	28,961	32,366	3,613
6 Bellevue	70.4	34,006	1,735	30,204	2,067
7a The Nations/Sylvan Park	9.1	12,791	2,862	8,995	634
7b Belle Meade/West Meade	16.3	26,991	1,881	23,590	1,920
8 North Nashville	7.5	22,594	20,928	1,121	536
9 Downtown	2.8	3,401	1,429	1,803	169
9a West End/Vanderbilt	6.4	32,206	10,641	19,134	2,511
9b Forest Hills/Oak Hill	32.6	42,182	895	40,030	1,257
11 Berry Hill/Woodbine	15.4	33,725	8,651	20,077	5,047
12 Tusculum/Crieve Hall	42.7	77,441	13,477	55,149	8,816
13 Priest Lake/Antioch	59.4	57,579	15,036	36,844	6,699
14 Donelson/Hermitage	62.5	72,711	7,141	61,419	4,151
TOTAL	625.4	668,891	147,696	381,783	49,412

Census Tracts in Davidson County, TN, 2000

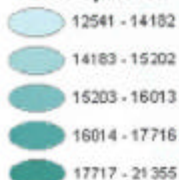


Metropolitan Council Districts In Davidson County, TN, 2000 (before 2003)

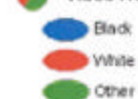


LEGEND

Total Population

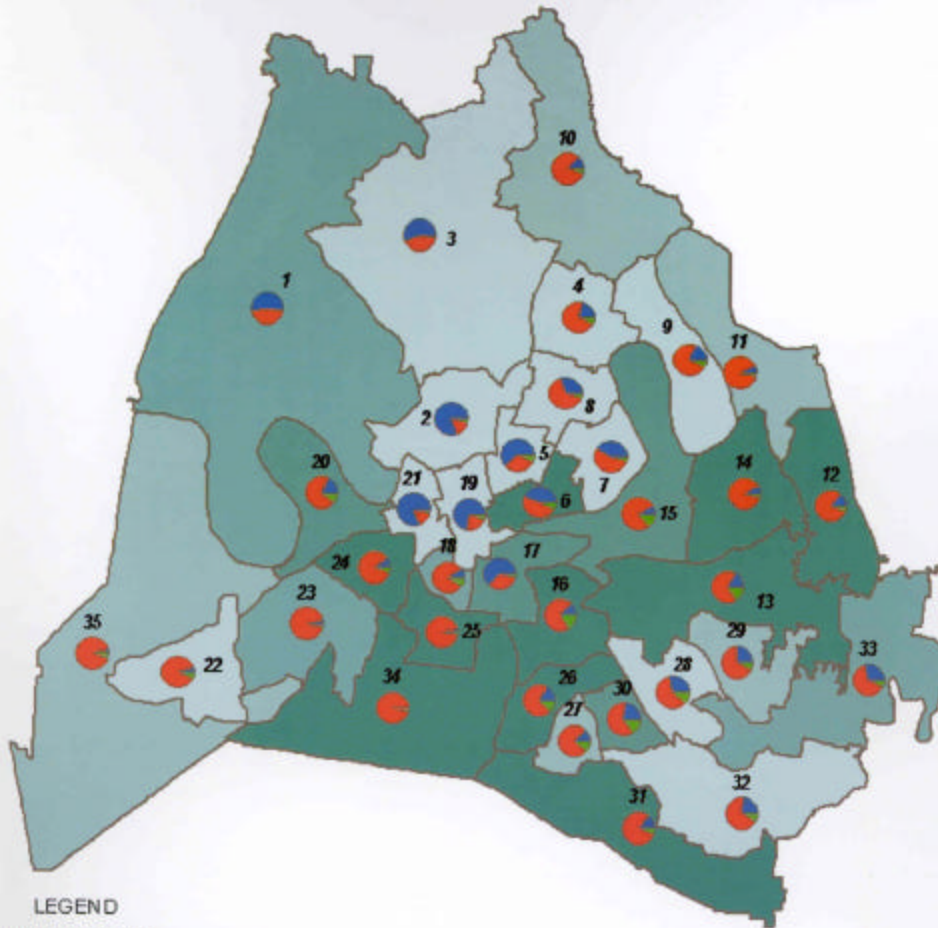


Race Ratio



Council District	Area (sq. mi.)	Population				Council District	Area (sq. mi.)	Population			
		Total	Black	White	Other			Total	Black	White	Other
1	98.3	15,114	5,804	8,949	261	19	4.9	12,659	8,891	4,240	729
2	9.6	15,039	12,277	2,367	514	20	5.5	12,666	11,252	1,273	241
3	14.5	15,419	4,272	10,404	734	21	4.3	15,122	8,282	4,281	960
4	8.0	16,788	18,493	5,635	702	22	18.1	14,892	2,554	10,834	1,464
5	3.4	13,838	18,072	1,814	740	23	43.9	12,716	952	15,644	1,120
6	7.6	14,182	5,748	7,512	922	24	8.8	15,869	1,555	12,852	962
7	5.2	14,911	6,718	7,578	615	25	4.6	15,862	785	14,786	292
8	5.1	15,537	2,598	11,894	947	26	4.4	16,817	3,523	10,182	2,800
9	11.1	17,178	3,140	12,866	1,258	27	9.1	12,873	4,222	10,428	1,823
10	42.1	16,813	2,015	13,500	298	28	8.7	21,537	5,518	13,788	2,231
11	15.0	16,862	1,163	15,217	582	29	17.7	21,886	6,550	14,288	1,208
12	35.9	21,440	2,804	17,459	1,177	30	3.5	14,810	3,740	9,627	2,043
13	14.5	12,494	2,354	11,210	3,252	31	24.5	21,138	4,742	15,038	1,298
14	9.0	14,272	1,590	12,588	592	32	7.4	19,212	1,388	16,238	1,265
15	16.7	15,263	1,009	12,785	1,527	33	10.8	15,172	1,748	14,632	792
16	5.6	14,439	1,656	10,268	2,515	34	14.4	15,263	1,465	14,718	257
17	3.8	12,541	7,212	4,828	501	35	28.0	21,264	894	19,544	1,117
18	2.0	148,481	951	12,228	1,575	70,744	525	589,887	142,690	288,753	40,472

Metropolitan Council Districts In Davidson County, TN, 2000 (new Council Districts effective 2003)

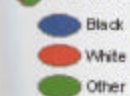


LEGEND

Total Population



Race Ratio



Council District	Area (sq. mi.)	Population				Council District	Area (sq. mi.)	Population			
		Total	Black	White	Other			Total	Black	White	Other
1	31.0	16,408	8,011	7,442	356	19	5.1	15,510	11,178	3,400	852
2	30.7	15,516	12,518	2,402	604	20	30.0	16,873	2,892	11,791	1,890
3	47.1	15,512	8,050	6,569	274	21	4.3	15,506	12,494	2,531	483
4	8.3	15,523	3,231	11,224	1,068	22	9.7	15,875	747	13,862	1,066
5	4.0	15,807	0,601	5,050	956	23	13.5	16,400	639	15,143	618
6	4.6	16,874	7,442	8,437	1,095	24	5.7	16,862	1,590	14,465	817
7	8.0	15,581	6,283	8,601	617	25	5.5	17,044	483	16,010	551
8	8.4	15,895	4,872	10,272	641	26	6.3	17,094	2,853	12,049	2,192
9	10.7	15,497	2,816	11,520	1,061	27	3.6	16,163	2,674	12,161	1,808
10	26.1	16,217	2,081	13,266	770	28	7.8	15,477	4,272	9,259	1,746
11	16.7	16,247	1,020	14,204	517	29	7.5	16,025	4,651	10,733	1,241
12	11.0	12,053	2,322	12,867	934	30	4.0	16,590	3,847	10,239	2,574
13	22.8	12,077	2,890	11,467	2,692	31	19.5	16,853	2,331	13,468	1,154
14	11.9	12,094	1,432	14,811	821	32	19.3	15,505	3,812	10,642	1,251
15	19.1	16,741	1,294	13,243	2,154	33	22.0	16,472	4,666	10,630	1,177
16	7.8	12,082	2,180	12,265	2,697	34	20.8	12,078	167	16,521	390
17	6.4	16,583	16,313	5,463	287	35	67.6	15,979	446	14,694	739
18	2.4	16,434	1,452	13,443	1,539	TOTAL	525	568,887	147,696	381,783	40,412